

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00090

00090

1. PLACE OF DEATH e. COUNTY <u>AA Co</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA Co</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lothian</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lothian</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Dawson</u> Middle <u>Armstrong</u> Last <u>Armstrong</u>		4. DATE OF DEATH Month <u>January</u> Day <u>16</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1894</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Armstrong</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Mills</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of bladder</u> 181.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>at least 2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 15, 1962</u> to <u>Jan. 16, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan. 15, 1962</u> and that death occurred at <u>1239</u> P.M. from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE <u>Willard F. Smith</u>		22b. DATE SIGNED <u>1/19/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH</u>		22d. ADDRESS <u>Shady Side, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-19-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT ZION Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>MT Zion, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>TA Hordest</u>		25a. REC'D BY REGISTRAR <u>JAN 24 1962</u>	
ADDRESS <u>San Galesville, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Wanda S. [unclear]</u>	

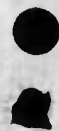
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00091

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00091

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Alco</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis Md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. ANNIE ARNOLD GEN.</u>				1d. STREET ADDRESS <u>702 Wm. Miller Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E</u> Last <u>Ashenfelter</u>				4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1962</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29-1912</u>		9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Linotype operator</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Grant County W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>	
13. FATHER'S NAME <u>C. O. Schartziger</u>				14. MOTHER'S MAIDEN NAME <u>Laura Alice Kessel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>J. B. Ashenfelter</u>		Address <u>702 Miller Rd Annapolis MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac</u> <u>434-4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/4/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Maple Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Petersburg W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Blaine Schaeffer</u>				ADDRESS <u>Petersburg W. Va.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>		DATE SIGNED <u>1-1-62</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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STATE OF NEW YORK - DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1003

(M)

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. BIRTH COUNTRY	
8. OCCUPATION		9. MARITAL STATUS		10. EDUCATION		11. RELIGION		12. SOCIAL CLASS		13. PRESENT ADDRESS		14. PRESENT CITY	
15. PRESENT STATE		16. PRESENT COUNTY		17. PRESENT TOWN		18. PRESENT VILLAGE		19. PRESENT CENSUS TRACT		20. PRESENT BLOCK		21. PRESENT HOUSE	
22. DATE OF DEATH		23. TIME OF DEATH		24. PLACE OF DEATH		25. CAUSE OF DEATH		26. MANNER OF DEATH		27. MEDICAL HISTORY		28. PRESENT ILLNESS	
29. PRESENT PHYSICIAN		30. PRESENT NURSE		31. PRESENT ATTENDING PHYSICIAN		32. PRESENT ASSISTANT PHYSICIAN		33. PRESENT DENTIST		34. PRESENT OPTICIAN		35. PRESENT PHARMACEUTICIAN	
36. PRESENT HOSPITAL		37. PRESENT CLINIC		38. PRESENT DISPENSARY		39. PRESENT LABORATORY		40. PRESENT X-RAY		41. PRESENT PATHOLOGY		42. PRESENT BACTERIOLOGY	
43. PRESENT PHYSICIAN'S SIGNATURE		44. PRESENT NURSE'S SIGNATURE		45. PRESENT ATTENDING PHYSICIAN'S SIGNATURE		46. PRESENT ASSISTANT PHYSICIAN'S SIGNATURE		47. PRESENT DENTIST'S SIGNATURE		48. PRESENT OPTICIAN'S SIGNATURE		49. PRESENT PHARMACEUTICIAN'S SIGNATURE	
50. PRESENT PHYSICIAN'S ADDRESS		51. PRESENT NURSE'S ADDRESS		52. PRESENT ATTENDING PHYSICIAN'S ADDRESS		53. PRESENT ASSISTANT PHYSICIAN'S ADDRESS		54. PRESENT DENTIST'S ADDRESS		55. PRESENT OPTICIAN'S ADDRESS		56. PRESENT PHARMACEUTICIAN'S ADDRESS	
57. PRESENT PHYSICIAN'S PHONE		58. PRESENT NURSE'S PHONE		59. PRESENT ATTENDING PHYSICIAN'S PHONE		60. PRESENT ASSISTANT PHYSICIAN'S PHONE		61. PRESENT DENTIST'S PHONE		62. PRESENT OPTICIAN'S PHONE		63. PRESENT PHARMACEUTICIAN'S PHONE	
64. PRESENT PHYSICIAN'S FAX		65. PRESENT NURSE'S FAX		66. PRESENT ATTENDING PHYSICIAN'S FAX		67. PRESENT ASSISTANT PHYSICIAN'S FAX		68. PRESENT DENTIST'S FAX		69. PRESENT OPTICIAN'S FAX		70. PRESENT PHARMACEUTICIAN'S FAX	
71. PRESENT PHYSICIAN'S E-MAIL		72. PRESENT NURSE'S E-MAIL		73. PRESENT ATTENDING PHYSICIAN'S E-MAIL		74. PRESENT ASSISTANT PHYSICIAN'S E-MAIL		75. PRESENT DENTIST'S E-MAIL		76. PRESENT OPTICIAN'S E-MAIL		77. PRESENT PHARMACEUTICIAN'S E-MAIL	
78. PRESENT PHYSICIAN'S SIGNATURE		79. PRESENT NURSE'S SIGNATURE		80. PRESENT ATTENDING PHYSICIAN'S SIGNATURE		81. PRESENT ASSISTANT PHYSICIAN'S SIGNATURE		82. PRESENT DENTIST'S SIGNATURE		83. PRESENT OPTICIAN'S SIGNATURE		84. PRESENT PHARMACEUTICIAN'S SIGNATURE	
85. PRESENT PHYSICIAN'S ADDRESS		86. PRESENT NURSE'S ADDRESS		87. PRESENT ATTENDING PHYSICIAN'S ADDRESS		88. PRESENT ASSISTANT PHYSICIAN'S ADDRESS		89. PRESENT DENTIST'S ADDRESS		90. PRESENT OPTICIAN'S ADDRESS		91. PRESENT PHARMACEUTICIAN'S ADDRESS	
92. PRESENT PHYSICIAN'S PHONE		93. PRESENT NURSE'S PHONE		94. PRESENT ATTENDING PHYSICIAN'S PHONE		95. PRESENT ASSISTANT PHYSICIAN'S PHONE		96. PRESENT DENTIST'S PHONE		97. PRESENT OPTICIAN'S PHONE		98. PRESENT PHARMACEUTICIAN'S PHONE	
99. PRESENT PHYSICIAN'S FAX		100. PRESENT NURSE'S FAX		101. PRESENT ATTENDING PHYSICIAN'S FAX		102. PRESENT ASSISTANT PHYSICIAN'S FAX		103. PRESENT DENTIST'S FAX		104. PRESENT OPTICIAN'S FAX		105. PRESENT PHARMACEUTICIAN'S FAX	
106. PRESENT PHYSICIAN'S E-MAIL		107. PRESENT NURSE'S E-MAIL		108. PRESENT ATTENDING PHYSICIAN'S E-MAIL		109. PRESENT ASSISTANT PHYSICIAN'S E-MAIL		110. PRESENT DENTIST'S E-MAIL		111. PRESENT OPTICIAN'S E-MAIL		112. PRESENT PHARMACEUTICIAN'S E-MAIL	
113. PRESENT PHYSICIAN'S SIGNATURE		114. PRESENT NURSE'S SIGNATURE		115. PRESENT ATTENDING PHYSICIAN'S SIGNATURE		116. PRESENT ASSISTANT PHYSICIAN'S SIGNATURE		117. PRESENT DENTIST'S SIGNATURE		118. PRESENT OPTICIAN'S SIGNATURE		119. PRESENT PHARMACEUTICIAN'S SIGNATURE	
120. PRESENT PHYSICIAN'S ADDRESS		121. PRESENT NURSE'S ADDRESS		122. PRESENT ATTENDING PHYSICIAN'S ADDRESS		123. PRESENT ASSISTANT PHYSICIAN'S ADDRESS		124. PRESENT DENTIST'S ADDRESS		125. PRESENT OPTICIAN'S ADDRESS		126. PRESENT PHARMACEUTICIAN'S ADDRESS	
127. PRESENT PHYSICIAN'S PHONE		128. PRESENT NURSE'S PHONE		129. PRESENT ATTENDING PHYSICIAN'S PHONE		130. PRESENT ASSISTANT PHYSICIAN'S PHONE		131. PRESENT DENTIST'S PHONE		132. PRESENT OPTICIAN'S PHONE		133. PRESENT PHARMACEUTICIAN'S PHONE	
134. PRESENT PHYSICIAN'S FAX		135. PRESENT NURSE'S FAX		136. PRESENT ATTENDING PHYSICIAN'S FAX		137. PRESENT ASSISTANT PHYSICIAN'S FAX		138. PRESENT DENTIST'S FAX		139. PRESENT OPTICIAN'S FAX		140. PRESENT PHARMACEUTICIAN'S FAX	
141. PRESENT PHYSICIAN'S E-MAIL		142. PRESENT NURSE'S E-MAIL		143. PRESENT ATTENDING PHYSICIAN'S E-MAIL		144. PRESENT ASSISTANT PHYSICIAN'S E-MAIL		145. PRESENT DENTIST'S E-MAIL		146. PRESENT OPTICIAN'S E-MAIL		147. PRESENT PHARMACEUTICIAN'S E-MAIL	
148. PRESENT PHYSICIAN'S SIGNATURE		149. PRESENT NURSE'S SIGNATURE		150. PRESENT ATTENDING PHYSICIAN'S SIGNATURE		151. PRESENT ASSISTANT PHYSICIAN'S SIGNATURE		152. PRESENT DENTIST'S SIGNATURE		153. PRESENT OPTICIAN'S SIGNATURE		154. PRESENT PHARMACEUTICIAN'S SIGNATURE	
155. PRESENT PHYSICIAN'S ADDRESS		156. PRESENT NURSE'S ADDRESS		157. PRESENT ATTENDING PHYSICIAN'S ADDRESS		158. PRESENT ASSISTANT PHYSICIAN'S ADDRESS		159. PRESENT DENTIST'S ADDRESS		160. PRESENT OPTICIAN'S ADDRESS		161. PRESENT PHARMACEUTICIAN'S ADDRESS	
162. PRESENT PHYSICIAN'S PHONE		163. PRESENT NURSE'S PHONE		164. PRESENT ATTENDING PHYSICIAN'S PHONE		165. PRESENT ASSISTANT PHYSICIAN'S PHONE		166. PRESENT DENTIST'S PHONE		167. PRESENT OPTICIAN'S PHONE		168. PRESENT PHARMACEUTICIAN'S PHONE	
169. PRESENT PHYSICIAN'S FAX		170. PRESENT NURSE'S FAX		171. PRESENT ATTENDING PHYSICIAN'S FAX		172. PRESENT ASSISTANT PHYSICIAN'S FAX		173. PRESENT DENTIST'S FAX		174. PRESENT OPTICIAN'S FAX		175. PRESENT PHARMACEUTICIAN'S FAX	
176. PRESENT PHYSICIAN'S E-MAIL		177. PRESENT NURSE'S E-MAIL		178. PRESENT ATTENDING PHYSICIAN'S E-MAIL		179. PRESENT ASSISTANT PHYSICIAN'S E-MAIL		180. PRESENT DENTIST'S E-MAIL		181. PRESENT OPTICIAN'S E-MAIL		182. PRESENT PHARMACEUTICIAN'S E-MAIL	
183. PRESENT PHYSICIAN'S SIGNATURE		184. PRESENT NURSE'S SIGNATURE		185. PRESENT ATTENDING PHYSICIAN'S SIGNATURE		186. PRESENT ASSISTANT PHYSICIAN'S SIGNATURE		187. PRESENT DENTIST'S SIGNATURE		188. PRESENT OPTICIAN'S SIGNATURE		189. PRESENT PHARMACEUTICIAN'S SIGNATURE	
190. PRESENT PHYSICIAN'S ADDRESS		191. PRESENT NURSE'S ADDRESS		192. PRESENT ATTENDING PHYSICIAN'S ADDRESS		193. PRESENT ASSISTANT PHYSICIAN'S ADDRESS		194. PRESENT DENTIST'S ADDRESS		195. PRESENT OPTICIAN'S ADDRESS		196. PRESENT PHARMACEUTICIAN'S ADDRESS	
197. PRESENT PHYSICIAN'S PHONE		198. PRESENT NURSE'S PHONE		199. PRESENT ATTENDING PHYSICIAN'S PHONE		200. PRESENT ASSISTANT PHYSICIAN'S PHONE		201. PRESENT DENTIST'S PHONE		202. PRESENT OPTICIAN'S PHONE		203. PRESENT PHARMACEUTICIAN'S PHONE	
204. PRESENT PHYSICIAN'S FAX		205. PRESENT NURSE'S FAX		206. PRESENT ATTENDING PHYSICIAN'S FAX		207. PRESENT ASSISTANT PHYSICIAN'S FAX		208. PRESENT DENTIST'S FAX		209. PRESENT OPTICIAN'S FAX		210. PRESENT PHARMACEUTICIAN'S FAX	
211. PRESENT PHYSICIAN'S E-MAIL		212. PRESENT NURSE'S E-MAIL		213. PRESENT ATTENDING PHYSICIAN'S E-MAIL		214. PRESENT ASSISTANT PHYSICIAN'S E-MAIL		215. PRESENT DENTIST'S E-MAIL		216. PRESENT OPTICIAN'S E-MAIL		217. PRESENT PHARMACEUTICIAN'S E-MAIL	
218. PRESENT PHYSICIAN'S SIGNATURE		219. PRESENT NURSE'S SIGNATURE		220. PRESENT ATTENDING PHYSICIAN'S SIGNATURE		221. PRESENT ASSISTANT PHYSICIAN'S SIGNATURE		222. PRESENT DENTIST'S SIGNATURE		223. PRESENT OPTICIAN'S SIGNATURE		224. PRESENT PHARMACEUTICIAN'S SIGNATURE	
225. PRESENT PHYSICIAN'S ADDRESS		226. PRESENT NURSE'S ADDRESS		227. PRESENT ATTENDING PHYSICIAN'S ADDRESS		228. PRESENT ASSISTANT PHYSICIAN'S ADDRESS		229. PRESENT DENTIST'S ADDRESS		230. PRESENT OPTICIAN'S ADDRESS		231. PRESENT PHARMACEUTICIAN'S ADDRESS	
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239. PRESENT PHYSICIAN'S FAX		240. PRESENT NURSE'S FAX		241. PRESENT ATTENDING PHYSICIAN'S FAX		242. PRESENT ASSISTANT PHYSICIAN'S FAX		243. PRESENT DENTIST'S FAX		244. PRESENT OPTICIAN'S FAX		245. PRESENT PHARMACEUTICIAN'S FAX	
246. PRESENT PHYSICIAN'S E-MAIL		247. PRESENT NURSE'S E-MAIL		248. PRESENT ATTENDING PHYSICIAN'S E-MAIL		249. PRESENT ASSISTANT PHYSICIAN'S E-MAIL		250. PRESENT DENTIST'S E-MAIL		251. PRESENT OPTICIAN'S E-MAIL		252. PRESENT PHARMACEUTICIAN'S E-MAIL	
253. PRESENT PHYSICIAN'S SIGNATURE		254. PRESENT NURSE'S SIGNATURE		255. PRESENT ATTENDING PHYSICIAN'S SIGNATURE		256. PRESENT ASSISTANT PHYSICIAN'S SIGNATURE		257. PRESENT DENTIST'S SIGNATURE		258. PRESENT OPTICIAN'S SIGNATURE		259. PRESENT PHARMACEUTICIAN'S SIGNATURE	
260. PRESENT PHYSICIAN'S ADDRESS		261. PRESENT NURSE'S ADDRESS		262. PRESENT ATTENDING PHYSICIAN'S ADDRESS		263. PRESENT ASSISTANT PHYSICIAN'S ADDRESS		264. PRESENT DENTIST'S ADDRESS		265. PRESENT OPTICIAN'S ADDRESS		266. PRESENT PHARMACEUTICIAN'S ADDRESS	
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309. PRESENT PHYSICIAN'S FAX		310. PRESENT NURSE'S FAX		311. PRESENT ATTENDING PHYSICIAN'S FAX		312. PRESENT ASSISTANT PHYSICIAN'S FAX		313. PRESENT DENTIST'S FAX		314. PRESENT OPTICIAN'S FAX		315. PRESENT PHARMACEUTICIAN'S FAX	
316. PRESENT PHYSICIAN'S E-MAIL		317. PRESENT NURSE'S E-MAIL		318. PRESENT ATTENDING PHYSICIAN'S E-MAIL		319. PRESENT ASSISTANT PHYSICIAN'S E-MAIL		320. PRESENT DENTIST'S E-MAIL		321. PRESENT OPTICIAN'S E-MAIL		322. PRESENT PHARMACEUTICIAN'S E-MAIL	
323. PRESENT PHYSICIAN'S SIGNATURE		324. PRESENT NURSE'S SIGNATURE		325. PRESENT ATTENDING PHYSICIAN'S SIGNATURE		326. PRESENT ASSISTANT PHYSICIAN'S SIGNATURE		327. PRESENT DENTIST'S SIGNATURE		328. PRESENT OPTICIAN'S SIGNATURE		329. PRESENT PHARMACEUTICIAN'S SIGNATURE	
330. PRESENT PHYSICIAN'S ADDRESS		331. PRESENT NURSE'S ADDRESS		332. PRESENT ATTENDING PHYSICIAN'S ADDRESS		333. PRESENT ASSISTANT PHYSICIAN'S ADDRESS		334. PRESENT DENTIST'S ADDRESS		335. PRESENT OPTICIAN'S ADDRESS		336. PRESENT PHARMACEUTICIAN'S ADDRESS	
337. PRESENT PHYSICIAN'S PHONE		338. PRESENT NURSE'S PHONE		339. PRESENT ATTENDING PHYSICIAN'S PHONE		340. PRESENT ASSISTANT PHYSICIAN'S PHONE		341. PRESENT DENTIST'S PHONE		342. PRESENT OPTICIAN'S PHONE		343. PRESENT PHARMACEUTICIAN'S PHONE	
344. PRESENT PHYSICIAN'S FAX		345. PRESENT NURSE'S FAX		346. PRESENT ATTENDING PHYSICIAN'S FAX		347. PRESENT ASSISTANT PHYSICIAN'S FAX		348. PRESENT DENTIST'S FAX		349. PRESENT OPTICIAN'S FAX		350. PRESENT PHARMACEUTICIAN'S FAX	
351. PRESENT PHYSICIAN'S E-MAIL		352. PRESENT NURSE'S E-MAIL		353. PRESENT ATTENDING PHYSICIAN'S E-MAIL		354. PRESENT ASSISTANT PHYSICIAN'S E-MAIL		355. PRESENT DENTIST'S E-MAIL		356. PRESENT OPTICIAN'S E-MAIL		357. PRESENT PHARMACEUTICIAN'S E-MAIL	
358. PRESENT PHYSICIAN'S SIGNATURE		359. PRESENT NURSE'S SIGNATURE		360. PRESENT ATTENDING PHYSICIAN'S SIGNATURE		361. PRESENT ASSISTANT PHYSICIAN'S SIGNATURE		362. PRESENT DENTIST'S SIGNATURE		363. PRESENT OPTICIAN'S SIGNATURE		364. PRESENT PHARMACEUTICIAN'S SIGNATURE	
365. PRESENT PHYSICIAN'S ADDRESS		366. PRESENT NURSE'S ADDRESS		367. PRESENT ATTENDING PHYSICIAN'S ADDRESS		368. PRESENT ASSISTANT PHYSICIAN'S ADDRESS		369. PRESENT DENTIST'S ADDRESS		370. PRESENT OPTICIAN'S ADDRESS		371. PRESENT PHARMACEUTICIAN'S ADDRESS	
372. PRESENT PHYSICIAN'S PHONE		373. PRESENT NURSE'S PHONE		374. PRESENT ATTENDING PHYSICIAN'S PHONE		375. PRESENT ASSISTANT PHYSICIAN'S PHONE		376. PRESENT DENTIST'S PHONE		377. PRESENT OPTICIAN'S PHONE		378. PRESENT PHARMACEUTICIAN'S PHONE	
379. PRESENT PHYSICIAN'S FAX		380. PRESENT NURSE'S FAX		381. PRESENT ATTENDING PHYSICIAN'S FAX		382. PRESENT ASSISTANT PHYSICIAN'S FAX		383. PRESENT DENTIST'S FAX		384. PRESENT OPTICIAN'S FAX		385. PRESENT PHARMACEUTICIAN'S FAX	
386. PRESENT PHYSICIAN'S E-MAIL		387. PRESENT NURSE'S E-MAIL		388. PRESENT ATTENDING PHYSICIAN'S E-MAIL		389. PRESENT ASSISTANT PHYSICIAN'S E-MAIL		390. PRESENT DENTIST'S E-MAIL		391. PRESENT OPTICIAN'S E-MAIL		392. PRESENT PHARMACEUTICIAN'S E-MAIL	
393. PRESENT PHYSICIAN'S SIGNATURE		394. PRESENT NURSE'S SIGNATURE		395. PRESENT ATTENDING PHYSICIAN'S SIGNATURE		396. PRESENT ASSISTANT PHYSICIAN'S SIGNATURE		397. PRESENT DENTIST'S SIGNATURE		398. PRESENT OPTICIAN'S SIGNATURE		399. PRESENT PHARMACEUTICIAN'S SIGNATURE	
400. PRESENT PHYSICIAN'S ADDRESS		401. PRESENT NURSE'S ADDRESS		402. PRESENT ATTENDING PHYSICIAN'S ADDRESS		403. PRESENT ASSISTANT PHYSICIAN'S ADDRESS		404. PRESENT DENTIST'S ADDRESS		405. PRESENT OPTICIAN'S ADDRESS		406. PRESENT PHARMACEUTICIAN'S ADDRESS	
407. PRESENT PHYSICIAN'S PHONE		408. PRESENT NURSE'S PHONE		409. PRESENT ATTENDING PHYSICIAN'S PHONE		410. PRESENT ASSISTANT PHYSICIAN'S PHONE		411. PRESENT DENTIST'S PHONE		412. PRESENT OPTICIAN'S PHONE		413. PRESENT PHARMACEUTICIAN'S PHONE	
414. PRESENT PHYSICIAN'S FAX		415. PRESENT NURSE'S FAX		416. PRESENT ATTENDING PHYSICIAN'S FAX		417. PRESENT ASSISTANT PHYSICIAN'S FAX		418. PRESENT DENTIST'S FAX		419. PRESENT OPTICIAN'S FAX		420. PRESENT PHARMACEUTICIAN'S FAX	
421. PRESENT PHYSICIAN'S E-MAIL		422. PRESENT NURSE'S E-MAIL		423. PRESENT ATTENDING PHYSICIAN'S E-MAIL		424. PRESENT ASSISTANT PHYSICIAN'S E-MAIL		425. PRESENT DENTIST'S E-MAIL		426. PRESENT OPTICIAN'S E-MAIL		427. PRESENT PHARMACEUTICIAN'S E-MAIL	
428. PRESENT PHYSICIAN'S SIGNATURE		429. PRESENT NURSE'S SIGNATURE		430. PRESENT ATTENDING PHYSICIAN'S SIGNATURE		431. PRESENT ASSISTANT PHYSICIAN'S SIGNATURE		432. PRESENT DENTIST'S SIGNATURE		433. PRESENT OPTICIAN'S SIGNATURE		434. PRESENT PHARMACEUTICIAN'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the registrar. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 100192

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MILLERSVILLE</b>				c. LENGTH OF STAY IN 1b <b>7 yr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MILLERSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 126-CRAIN HWY.</b>				d. STREET ADDRESS <b>Crain highway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ROSCOE LOUCKS AUGSBURY</b>				4. DATE OF DEATH Month Day Year <b>1/3/ 1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/23/1900</b>	
				9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MOTEL</b>		11. BIRTHPLACE (State or foreign country) <b>CORUNAA, MICHIGAN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ELMER F. AUGS BURY (dec)</b>				14. MOTHER'S MAIDEN NAME <b>MARY ELIZ. LOUCKS (dec)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-36-1616</b>		17. INFORMANT Address <b>OLIVE M. AUGSBURY. (WIFE) SAME ADDRESS</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY INFARCTION</b> DUE TO <b>HYPERTENSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>OVERWEIGHT</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>6 yr</b> <b>6 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>11-24- 1958</b> to <b>present</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>12-13 1961</b> , and that death occurred at <b>15 45</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>425 S. RITCHIE HWY GLEN BURNIE, MD.</b> DATE SIGNED <b>4 DEC 61</b>							
ACTUAL SIGNATURE <b>H.F. Manuzak</b>				PHYSICIAN'S NAME (Type) <b>H.F. Manuzak</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 8, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Owosso, Michigan</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard V. Singleton</b>				ADDRESS <b>Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 8 '62</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

INDIAN STATE DEPARTMENT OF HEALTH-BALTIMORE 18

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TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00093					00093				
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>8 mos. 9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>416 Orchard Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Arthur</u> Middle <u>V</u> Last <u>Bailey</u>					<b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>20</u> Year <u>1962</u>				
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>February 11, 1902</u>		<b>9. AGE</b> (In years last birthday) <u>59</u> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Waiter</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> -----		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New Orleans</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>William Bailey</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Pearl</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>		<b>17. INFORMANT</b> <u>Hospital Records</u> Address -----					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) ----- Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pyelonephritis</u>								<b>INTERVAL BETWEEN ONSET AND DEATH</b> -----	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) -----					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>-----</u> e.m. <u>-----</u> 19 <u>-----</u> p.m. <u>-----</u>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) -----		<b>20f. (City or town)</b> (County) (State) -----	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>11/3</u> , 19 <u>60</u> , to <u>1/20</u> , 1962, that (I) (we) last saw the deceased alive on <u>1/20</u> , 19 <u>62</u> , and that death occurred at <u>1210 P</u> from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <u>Hildegard Heard Reissman</u> M.D.					<b>22b. DATE SIGNED</b> <u>1/22/62</u>				
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Hildegard Heard Reissman, M. D. Crownsville State Hospital, Maryland</u>					<b>22d. ADDRESS</b> -----				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>		<b>23b. DATE THEREOF</b> <u>1-29-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>217 Md.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Balto. Md.</u>			
<b>24. MINERAL DIRECTOR'S SIGNATURE</b> <u>William Reese, Jr. - Annap. Md.</u>					<b>25a. REC'D BY REGISTRAR</b> DATE <u>JAN 31 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Haines</u>		

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TO HOSPITAL OR FUNERAL HOME: This law requires that the death certificate be executed within 24 hours after death. Page 1 is to be retained by the hospital or attending physician. Page 2 is to be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
00094		Items 23a & b, Film G205 1/17/62 iwk				00094								
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Odenton</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Odenton</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Odenton (Wilson town)</u>					d. STREET ADDRESS <u>Wilson town</u>									
3. NAME OF DECEASED (Type or print) <u>Odell S Barbour</u>					4. DATE OF DEATH <u>Jan 9 1962</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 15, 1896</u>		9. AGE (In years last birthday) <u>65</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School System</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
13. FATHER'S NAME <u>George Dallas Scott</u>					14. MOTHER'S MAIDEN NAME <u>Sarah Davis</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>—</u>					17. INFORMANT <u>Amy Scott Rose, Odenton, Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 287X DUE TO (b) <u>Severe Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Obesity</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>7 yrs</u> <u>7 yrs</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, lectory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from <u>July 1955</u> to <u>Jan 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 8, 1962</u> and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.														
22a. SIGNATURE <u>Henry A. Wise Jr</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <u>1/9/62</u>				
22c. PHYSICIAN'S NAME (Type) <u>Henry A. Wise Jr</u>					22d. ADDRESS <u>149 95 St. Bowie, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>Jan. 15, 1962</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Franklin</u>				
23d. LOCATION (City, town or county) <u>Odenton</u>					(State) <u>Md.</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Johnson, Box 462, Annapolis, Md.</u>					ADDRESS					25a. REC'D BY REGISTRAR <u>Arthur E. Hanna</u>				
DATE <u>JAN 12 '62</u>					25b. REGISTRAR'S SIGNATURE									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00095

00095

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>115 Riverside Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>E.</b> Last <b>Barnes</b>		4. DATE OF DEATH Month <b>1</b> Day <b>10</b> Year <b>19 62</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/22/88</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Calvert Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Barnes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Family</b>	
17. INFORMANT <b>Family</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary atherosclerosis</b> <b>49 2x</b> DUE TO <b>acute fibrillation. Pericarditis virus.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>See last column. Rheumatoid arthritis.</b> (c) <b>See last column. Rheumatoid arthritis.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>295. Diabetes &amp; forward pericarditis rheum. arthritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1st</b> 19 <b>62</b> to <b>Jan 1st</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>Jan 1st</b> 19 <b>62</b> , and that death occurred at <b>11:01 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Key Summers</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Key Summers M.D.</b>		22d. ADDRESS <b>1101 Beechwood Ave</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/12/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Homes 130 E. Fort Ave.</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 12 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

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TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00096 CERTIFICATE OF DEATH 00096

1. PLACE OF DEATH a. COUNTY <b>Maryland</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Millersville</b>		c. LENGTH OF STAY IN 1b <b>1</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Knollwood Manor</b>		d. STREET ADDRESS <b>420 B and A. Blvd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LEMON BEALL JR</b>		4. DATE OF DEATH <b>May 8, 1962</b>		Month <b>1</b> Day <b>9</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1887</b>	9. AGE (In years last birthday) <b>74 yrs.</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>9</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tabacco</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Davidsonville, Maryland</b>	
13. FATHER'S NAME <b>Lemon Beall Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Ann R. Anderson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213 12 9417</b>		17. INFORMANT <b>Mrs. Lucy C. Beall Wife</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>same as #2</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>Years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>9/19/1961</b>	
20f. (City or town) <b>12/19/62</b>		20g. (County) <b>12/19/62</b>		20h. (State) <b>12/19/62</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>9/19/1961</b> to <b>12/19/1962</b> that (I) (wa) last saw the deceased alive on <b>12/25/1961</b> , and that death occurred <b>May 8, 1962</b> at <b>420 B and A. Blvd.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>G. Churett</b>		22b. DATE SIGNED <b>May 8, 1962</b>		22c. PHYSICIAN'S NAME (Type) <b>G. Churett</b>	
22d. ADDRESS <b>121 E. CHURCH ST. ANNAPOLIS</b>		22e. DATE <b>JAN 15 '62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 12, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>All Hallows Chapel</b>	
23d. LOCATION (City, town or county) <b>Davidsonville, Md.</b>		23e. (State) <b>Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		24b. ADDRESS <b>Annapolis, Md.</b>		25a. REC'D BY REGISTRAR <b>Arthur S. Knott</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knott</b>		25c. DATE <b>JAN 15 '62</b>			

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00097  
CERTIFICATE OF DEATH  
00097

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>109 Sims Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy</b>		4. DATE OF DEATH <b>January 25 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 25, 1962</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newborn</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>3</b> yrs. IF UNDER 1 YEAR Months Days <b>3 10</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Stephen Nick Belichick</b>		14. MOTHER'S MAIDEN NAME <b>Jeannette Ruth Munn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Congenital Dysmatur</b> 754.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>Michael Sims</b> attended the deceased from <b>Jan. 25, 1962</b> to <b>Jan. 25, 1962</b> , that (I) <b>Michael Sims</b> saw the deceased alive on <b>Jan. 25, 1962</b> , and that death occurred at <b>6:40 AM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Niel H. Sims</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>1/26/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Niel H. Sims, M.D.</b>		22d. ADDRESS <b>95 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>1-26-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>H. Lincoln</b>		23d. LOCATION (City, town or county) (State) <b>Bladensburg Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor</b>		25a. REC'D BY REGISTRAR <b>JAN 29 62</b>	
ADDRESS <b>Annapolis, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>John M. Taylor</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00098

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>35 Hicks Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Baley</b>		4. DATE OF DEATH Month <b>January</b> Day <b>7</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 6, 1962</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>17</b> Months <b>45</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Oliver Franklin Randall</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Delores Blake</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. INFORMANT <b>Hospital records Oliver Randall 8 Bunch</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, (c) <b>Prematurity</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>BOBBY</b> attended the deceased from <b>Jan. 6, 1962</b> to <b>Jan. 6, 1962</b> , that (I) <b>see</b> last saw the deceased alive on <b>Jan. 6, 1962</b> , and that death occurred at <b>6:15 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Clayton Norton</b> M.D.		22b. DATE SIGNED <b>1/9/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Clayton Norton, M.D.</b>		22d. ADDRESS <b>Medical Building, Severna Park, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 1-12-1962</b>		23b. DATE THEREOF <b>1-12-1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill Annapolis Md</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese</b>		25a. REC'D BY REGISTRAR <b>Jan 15 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		25c. DATE	

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN lb ?		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24		3001-4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Behind Gibson Island Country School				d. STREET ADDRESS 317 N. Robinson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Middle		Last		4. DATE OF DEATH January 30th. 19 62	
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/19/24	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Bowen				14. MOTHER'S MAIDEN NAME Josephine Krauss			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes Navy War 11		16. SOCIAL SECURITY NO. 217-12-3302		17. INFORMANT Mrs. Marguerite Sheldon (sister).		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Poisoning by Carbon Monoxide (Suicide) 773.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause first. } DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) other end under the back seat. By fastening one end of a rubber hose to the exhaust pipe and the					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. ? 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Behind Gibson Country School, Pasadena, A.A. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Gustave H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 1/30/62 DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Glen Burnie, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-2-62		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore County	
23. FUNERAL DIRECTOR Wm. Cook, Inc., 1217 St. Paul Street, ZONE 2				24a. REC'D BY REGISTRAR DATE FEB 2 '62		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled out. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>A.A.CO.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.CO.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GLENBURNIE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1509 TIEMAN DR.</u>		d. STREET ADDRESS <u>1509 TIEMAN DR.</u>	
3. NAME OF DECEASED (Type or print) <u>JEANNIE BOWEN</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>19</u> Year <u>1962</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 26, 1877</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>SCOTLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN ROSS</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET MCGREGOR.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS GLADYS HEADS,</u>		Address <u>1509 TIEMAN DR, GLENBURNIE A.A.CO., MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular disease</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>diabetes</u> DUE TO (c) <u>accelerated thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5yr</u> <u>1yr</u> <u>2da</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1952</u> to <u>Jan 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 19</u> 19 <u>62</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>Jan 20/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS <u>1138 North Baltimore</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/23/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u>		23d. LOCATION (City, town or county) (State) <u>WOODLAWN MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE, 4101 EDMONDSON AVE.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 23 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u> c. LENGTH OF STAY IN 1b <u>39 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt. 2 Box - 117</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u> d. STREET ADDRESS <u>Rt. 2 Box - 117</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>R. Melvin Boyer</u>		<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>11th</u> Year <u>1962</u>		<b>5. SEX</b> <u>Male</u>			
<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>27 Jan. 1882</u>			
<b>9. AGE</b> (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Conductor (Ret) Pa. Rail Road</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Severn, Maryland</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Josephus Boyer</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Victory Gaither</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>717-07-5811</u>		<b>17. INFORMANT</b> <u>Mrs. Bernice Stinchcomb, Same as #2</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> (b) <u>Hypertensive arteriosclerotic Heart Disease</u> (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> <u>  </u> <u>  </u> Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>  </u>		<b>20g. (County)</b> <u>  </u>		<b>20h. (State)</b> <u>  </u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec. 1949</u> <b>to</b> <u>Nov 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>JAN 2 1962</u> <b>and that death occurred at</b> <u>8:30 PM</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>R. MacDonnell</u>		<b>22b. DATE SIGNED</b> <u>1-14-62</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>204 Crain Hwy. Glen Burnie Md</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1-15-1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Meadowridge Mem'l Park</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Wash. Blvd. Howard Co., Md.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Singleton Funeral Home / Robert P. Ware, md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>  </u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>		<b>25c. DATE</b> <u>JAN 16 '62</u>		<b>25d. REGISTRAR'S SIGNATURE</b> <u>  </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained in the hospital or attending physician's office for a period of 72 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>AA</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> c. LENGTH OF STAY IN 1b <i>10</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>142 Charles St</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>AA</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> d. STREET ADDRESS <i>142 Charles St</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Catherine</i> First <i>Alipia</i> Middle <i>Brady</i> Last 4. DATE OF DEATH Month <i>1</i> Day <i>6</i> Year <i>1962</i>		5. SEX <i>Female</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>12-6-1878</i> 9. AGE (In years last birthday) <i>83</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> 11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i> 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>John J. Piordan</i> 14. MOTHER'S MAIDEN NAME <i>Catherine McCake</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>—</i> 16. SOCIAL SECURITY NO. <i>—</i> 17. INFORMANT Address <i>Mrs Ann Tucker</i> (2)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>Diabetes mellitus</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Diabetes mellitus</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> <i>1 yr.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <i>—</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i> 20f. (City or town) (County) (State) <i>Annapolis Md</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 30 1959</i> to <i>Jan 6 1962</i> that (I) (we) last saw the deceased alive on <i>1-3-1962</i> and that death occurred at <i>—</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>James R. Martin</i> 22b. DATE SIGNED <i>1-8-61</i>		22c. PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i> 22d. ADDRESS <i>6 SHAW ST. ANNAPOLIS, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 23b. DATE THEREOF <i>1-9-1962</i> 23c. NAME OF CEMETERY OR CREMATORY <i>St Marys Cemt</i> 23d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>		24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor</i> ADDRESS <i>Annapolis Md</i> 25a. REC'D BY REGISTRAR DATE <i>JAN 9 '62</i> 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY <b>23 Months</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Plaza Manor Nursing Home</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City 17</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City 17</b> d. STREET ADDRESS <b>1231 Pennsylvania Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>John H. Briday</b>			4. DATE OF DEATH Month <b>January 5</b> Year <b>1962</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>5-20-1889</b>	9. AGE (In years last birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Richmond, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>John Briday</b>		
14. MOTHER'S MAIDEN NAME <b>Anne ?</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W.W. 1</b>		
16. SOCIAL SECURITY NO. <b>149-05-9317</b>			17. INFORMANT <b>Mr. Adler-Balto. City D.P.W.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epilepsy</b>					INTERVAL BETWEEN ONSET AND DEATH <b>? yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>2-20-1960</b> , 19....., to <b>1-5-1962</b> , 19....., that (I) ( <del>was</del> ) last saw the deceased alive on <b>December 22 1961</b> , and that death occurred at <b>7A</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>James M. Pair</b> M.D.			22b. DATE SIGNED <b>1-5-1962</b>		
22c. PHYSICIAN'S NAME (Type) <b>James M. Pair, M.D.</b>			22d. ADDRESS <b>400 N. Carrollton Ave. Balto. 23, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-9-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b> ADDRESS <b>802 Madison Avenue, Balto., Md.</b>			25a. REC'D BY REGISTRAR DATE <b>JAN 10 '62</b>		
25b. REGISTRAR'S SIGNATURE <b>William S. Plummer</b>					



00103

James Randall

Don Smith

23 North

Bellevue City, N.Y.

England

James Henry Howard

1231 Pennsylvania Avenue

John H. Baker

January 2

John H. Baker

2-20-1982

TS

Robert

Robert

Robert, N.Y. 100

U.S.A.

John Baker

John Baker

...

110-02-9317

Mr. Arthur W. Co. City, N.Y.

Governmental and commercial affairs

NYC

College

December 12-81

2-2-1980

1-3-1982

1-1-1982

James W. Baker

100 W. Garrison Ave. N.Y.C. 10011

1-1-82

1-1-82

1-1-82

Charles W. Baker, 100 W. Garrison Ave. N.Y.C. 10011



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00104

00104

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> <span style="float: right;">c. LENGTH OF STAY IN 1b</span> <u>6 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>105 Longwood Ave.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Anne Arundel</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>105 Longwood Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Bertha</u> <span style="float: right;">First</span> <u>A.</u> <span style="float: right;">Middle</span> <u>Brigerman</u> <span style="float: right;">Last</span>			<b>4. DATE OF DEATH</b> <u>Jan.</u> <span style="float: right;">Month</span> <u>16</u> <span style="float: right;">Day</span> <u>1962</u> <span style="float: right;">Year</span>				
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>11-28-1892</u> <span style="float: right;">9. AGE (In years last birthday)</span> <u>69</u> <span style="float: right;">yrs.</span>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> -----		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			<b>13. FATHER'S NAME</b> <u>WAX Wilhelm Reinke</u>				
<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				
<b>16. SOCIAL SECURITY NO.</b> -----			<b>17. INFORMANT</b> <u>Mrs. Lorraine Brigerman 105 Longwood Ave.</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> (b) <u>Hypertensive cardiovascular disease</u> (c) <u>diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>none</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>July 10, 1954</u> <b>to</b> <u>January 16, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>January 15, 1962</u> <b>and that death occurred at</b> <u>10 P.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>R. M. McLaughlin</u> <span style="float: right;">M.D.</span>			<b>22b. ADDRESS</b> <u>3708 Monmouth Rd. Pasadena, Md.</u>				
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>R. M. McLaughlin</u>			<b>22d. DATE SIGNED</b> <u>1/16/62</u>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1/19/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Glen Haven Cemetery</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Glen Burnie, Maryland</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles L. Stevens</u> <span style="float: right;">ADDRESS</span> <u>Funeral Home, Inc. 1501 E. Fort Ave.</u>					
<b>25a. REC'D BY REGISTRAR</b> <u>DAWN 22 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Wm. S. Evans</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

2020

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
00105					00105				
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>2 years 2 mos. 9 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Md. (D.C.)</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>6407 Kolb St., N. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Grace M Brooks</b>					4. DATE OF DEATH Month <b>1</b> Day <b>13</b> Year <b>1962</b>				
5. SEX <b>Female</b>					6. COLOR OR RACE <b>Negro</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>September 3, 1937</b>				
9. AGE (In years last birthday) <b>24 yrs.</b>					10. IF UNDER 1 YEAR Months <b>24</b> Days <b>16</b> Hours <b>30</b> Min. <b>2</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>				
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>James Butler</b>					14. MOTHER'S MAIDEN NAME <b>Alice Rice</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Unknown</b>					16. SOCIAL SECURITY NO. <b>577-34-8775</b>				
17. INFORMANT <b>Hospital Records</b>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO (b) <b>Bilateral Empyema</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <b>Pulmonary Abscess</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>-----</b> p.m. <b>19</b> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b> 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>2/29/56</b> to <b>1/13/62</b> , that (I) (we) last saw the deceased alive on <b>1/13/62</b> , and that death occurred at <b>11:20 p.m.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Lionel McHenry Mapp, M. D.</b> 22b. DATE SIGNED <b>1/15/62</b> 22c. PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b> 22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>1-18-62</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b> 23d. LOCATION (City, town or county) <b>Washington, D.C. V.A.</b>									
24. FUNERAL DIRECTOR'S SIGNATURE <b>Rollins, Myrtle K</b> ADDRESS <b>4339 Newt P.P. Rd</b> 25a. REC'D BY REGISTRAR <b>JAN 17 '62</b> 25b. REGISTRAR'S SIGNATURE <b>C. L. S. Harris</b>									

20100

M

rice

1-1-62 Mr. J. B. McQuinn

3. *Staphylococcus aureus*

TO HOSPITAL OR AFTER DEATH. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Justine</b> Middle <b>W.</b> Last <b>BROSEKER, Sr</b>		4. DATE OF DEATH Month <b>January</b> Day <b>18</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 8, 1911</b>
9. AGE (In years last birthday) <b>50 yrs.</b>		IF UNDER 1 YEAR Months <b>50</b> Days <b>18</b> Hours <b>19</b> Min. <b>62</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>G.E.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Roland Broseker</b>	
14. MOTHER'S MAIDEN NAME <b>Nora Ward (Dec)</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Violet Broseker</b> Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary metastases</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Carcinoma of the rectum</b> DUE TO (c) <b>3 1/2 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>HOCHMAN</b> attended the deceased from <b>Jan. 16, 1962</b> to <b>Jan. 18, 1962</b> that (I) <b>last</b> saw the deceased alive on <b>Jan. 18, 1962</b> , and that death occurred at <b>4:45 AM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Richard I. Hochman</b> M.D.	
22b. DATE SIGNED <b>1/18/62</b>		22c. PHYSICIAN'S NAME (Type) <b>Richard I. Hochman</b>	
22d. ADDRESS <b>59 Franklin St., Annapolis, Md.</b>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>22 Jan 62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>		23d. LOCATION (City, town or county) (State) <b>Glen Burnie Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping &amp; Kirkley</b>		25a. REC'D BY REGISTRAR <b>JAN 23 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>William S. Kraus</b>		25c. ADDRESS <b>Glen Burnie Md.</b>	

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00107 CERTIFICATE OF DEATH 01428

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>Mins.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>99 East St.</b>	
3. NAME OF DECEASED (Type or print) <b>Anthony BROWN</b>		4. DATE OF DEATH Month <b>January</b> Day <b>25</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 19-1898</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months <b>63</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gen. Utilities - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13. FATHER'S NAME <b>Anthony Brown</b>		14. MOTHER'S MAIDEN NAME <b>Alverta Owings</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W.1</b>		16. SOCIAL SECURITY NO. <b>214-05-0839</b>	
17. INFORMANT <b>Joseph Brown - 99 East St. Anna. Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>420</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Acute pulmonary Hypertension</b> DUE TO (c) <b>Coronary Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE: CONDITION GIVEN IN PART I <b>Old Myocardial Infarct</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>Jan. 25, 1962</b> to <b>Jan. 25, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan. 25, 1962</b> , and that death occurred at <b>10:25 PM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>R. L. Richardson</b> M.D.	
22b. DATE <b>1/27/62</b>		22c. PHYSICIAN'S NAME (Type) <b>R. L. Richardson, M.D.</b>	
22d. ADDRESS <b>110 Clay St., Annapolis, Md.</b>		22e. DATE <b>1/27/62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-29-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>		23d. LOCATION (City, town or county) (State) <b>Annapolis, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Hicks</b>		24. ADDRESS <b>111 Annapolis, Maryland</b>	
25a. REC'D BY REGISTRAR <b>FEB 7 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Walter A. Thurston</b>	

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Alvin Karpis

Alvin Karpis

Alvin Karpis - born 1901, Chicago, Ill.

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1901-08-17

*Alvin Karpis - born 1901, Chicago, Ill. - died 1935, St. Paul, Minn.*

*Alvin Karpis*

Alvin Karpis, born 1901, Chicago, Ill.

Alvin Karpis, born 1901, Chicago, Ill.

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Alvin Karpis, born 1901, Chicago, Ill.

Alvin Karpis, born 1901, Chicago, Ill.



00103

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Jan. 17, 1965

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00109

## CERTIFICATE OF DEATH

00108

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>6 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Crownsville</u>	
		d. STREET ADDRESS <u>Button Wood Trail</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Nelson</u> Middle <u>M</u> Last <u>BROWN</u>		<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>8</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1894</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> <u>no</u>		16. SOCIAL SECURITY NO. <u>275 12 6437</u>	17. INFORMANT <u>Mrs. Iris E. Brown- Wife- Same as # 2</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Post. coronary artery occlusion</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO (c) <u>acute Bronchitis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (the doctor) attended the deceased from <u>Jan. 7, 1962</u> to <u>Jan. 7, 1962</u> that (I) (the doctor) saw the deceased alive on <u>Jan. 7, 1962</u> , and that death occurred at <u>5:45 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Emily A. Wilson</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Lothian, Md.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Emily H. Wilson</u>		22b. DATE SIGNED <u>1/9/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 11, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>
23d. LOCATION (City, town or county) <u>Annapolis, Md.</u>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Md.</u>	
25a. REC'D BY REGISTRAR DATE <u>JAN 15 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00110  
01430  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL - Lothian</b>			
c. LENGTH OF STAY IN lb <b>6 days</b>				d. STREET ADDRESS <b>RURAL</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>BROWN</b> Last <b>BROWN</b>				4. DATE OF DEATH Month <b>January</b> Day <b>28</b> Year <b>1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 15, 1876</b>	
9. AGE (In years last birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARETAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Priscilla Owens</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hattie Smith-76 Clay St. Annapolis, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Congestive heart failure due to Chronic atherosclerotic Heart disease</b> Conditions, if any, which gave rise to immediate cause (b) <b>DUE TO</b> (c) <b>Hypertensive Cardiovascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>Jan. 22, 1962</b> to <b>Jan. 28, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan. 28, 1962</b> , and that death occurred at <b>11:14 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>R. L. Richardson</b>				22b. DATE SIGNED <b>1/31/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>R. L. Richardson</b>				22d. ADDRESS <b>110 Clay St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb 1-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>		23d. LOCATION (City, town or county) (State) <b>Lothian, A.A.Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Hicks III</b>				ADDRESS <b>Annapolis, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 7 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00111

00109

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>AA. Co</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Laurel</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Laurel</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Old Annapolis Rd</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Ida Erilla Buchanan</i>				4. DATE OF DEATH Month Day Year <i>January 25 1962</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 16, 1892</i>	9. AGE (In years lost birthday) <i>69 yrs.</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Andrew Goodfellow Buchanan</i>				14. MOTHER'S MAIDEN NAME <i>Carrie Marshall Taylor</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>705-05-2409</i>		17. INFORMANT Address <i>Mrs Dora Lindamood, Laurel Md (RFD)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocarditis</i> <i>260X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic Myocarditis</i> DUE TO (c) <i>Myocarditis</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>18 mo</i> <i>5 yr.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>April 20, 1961</i> to <i>Jan 25, 1962</i> , that (I) (we) lost the deceased on <i>Jan 25, 1962</i> , and that death occurred at <i>3 P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Robert S. McCeney</i>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <i>ROBERT S. MCCENEY, M.D.</i>	
22d. ADDRESS <i>402 MAIN ST.</i>							
23a. BURIAL, CREMATION, REMAINS (Type)		23b. DATE OF BURIAL, CREMATION, ETC. <i>1-29-62</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Mount</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore City, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Brooks Funeral Service, Inc., Towson 4, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>JAN 29 '62</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. House</i>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00112

## CERTIFICATE OF DEATH

Reg. Dist. No.

00110

1. PLACE OF DEATH a. COUNTY <u>HA.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HA.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cap St Clair</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cap St Clair</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hickock View Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EARL</u> Middle <u>C</u> Last <u>BURKE</u>		4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-4-94</u> AGE (In years last birthday) <u>67</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Eng</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B+C.</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Ind.</u>	
13. FATHER'S NAME <u>T. Los.</u>		14. MOTHER'S MAIDEN NAME <u>E. L. J. Solley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give branch and dates of service) <u>Yes. WWI</u>		16. SOCIAL SECURITY NO. <u>Family - Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic coronary insufficiency</u> DUE TO (c) <u>Subacute pulmonary congestion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>3 yrs</u> <u>12 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. AGENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1959</u> to <u>Jan 1st 1962</u> that I last saw the deceased alive on <u>January 1st 1962</u> , and that death occurred at <u>3:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bertrand C R Gau</u>		ADDRESS (Street, city or town, state) <u>Cape St Clair</u> DATE SIGNED <u>1-2-62</u>	
PHYSICIAN'S NAME (Type) <u>Bertrand C R Gau</u>		<u>Rt 4 Annapolis Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1/5/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Holt Cer.</u>		24a. REC'D BY REGISTRAR <u>John E. Holt Cer.</u> DATE <u>JAN 5 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>William B. Knease</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

001113 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

001111

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Michigan</u> b. COUNTY <u>Okland</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Walled Lake (Middle Straights Lake) Rural Lake</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>7730 Detroit Blvd., 59X-3</u>			
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>R</u> Last <u>CONTI</u>				4. DATE OF DEATH Month <u>January</u> Day <u>16</u> Year <u>19 62</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 24, 1914</u> 47 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tool Manf. Co.</u>		9. AGE (In years last birthday) <u>47</u> yrs.	
11. BIRTHPLACE (State or foreign country) <u>Ill.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Conti</u>				14. MOTHER'S MAIDEN NAME <u>Clara Graf</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>326 05 9423</u>			
17. INFORMANT <u>Mrs. Gertrude Conti</u>				Address <u>Wife same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest, cause undetermined</u> 54130 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bleeding duodenal ulcer with massive hemorrhage</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary edema</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 days</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Elmer G. Linhardt</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>Jan. 18, 1962</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Hopping Funeral Home</u>				22d. LOCATION (City, town, or country) (State) <u>Walled Lake, Michigan</u>			
23. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 19 '62</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be filled by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00114

00112

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Shadyside</u>	
c. LENGTH OF STAY IN <u>10 days</u>		d. STREET ADDRESS <u>Box-13</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Elizabeth</u> Middle <u>COOPER</u> Last <u>January</u>		<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>12</u> Year <u>19 62</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>March 2, 1892</u>
<b>9. AGE</b> (In years last birthday) <u>69 yrs.</u>		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>Jim Randolph</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Myatts</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>	
<b>17. INFORMANT</b> <u>Caryle B. Matthews</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause or line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Diabetes mellitus</u>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	
<b>20c. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		<b>20d. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
<b>20e. (City or town)</b> <u>  </u>		<b>20f. (County)</b> <u>  </u>	
<b>20g. (State)</b> <u>  </u>		<b>21. I certify that (I) <u>Willard F. Smith</u> attended the deceased from <u>Dec. 31, 1961</u> to <u>Jan 12, 1962</u>, that (I) <u>was</u> last saw the deceased alive on <u>Jan. 12, 1962</u>, and that death occurred at <u>10:15 AM</u>, from the causes and on the date stated above.</b>	
<b>22a. SIGNATURE</b> <u>Willard F. Smith</u>		<b>22b. DATE SIGNED</b> <u>1/12/62</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Willard F. Smith</u>		<b>22d. ADDRESS</b> <u>Shadyside, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1-15-62</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Thesalonica Baptist</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Forks Union, Va.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>William Reese, Jr.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>  </u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. House</u>		<b>DATE</b> <u>JAN 15 '62</u>	

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00115

00113

1. PLACE OF DEATH a. COUNTY <b>AA</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Balto.</b> b. COUNTY <b>AA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glnr Burnie</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1108 Nottingham Dr.</b>				d. STREET ADDRESS <b>1108 Nottingham Dr.</b>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>F.</b> Last <b>Cooper</b>				4. DATE OF DEATH Month <b>1</b> Day <b>25</b> Year <b>19 62</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/20/93</b>		9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rigger</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beth</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frank E. Cooper</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Fier</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Family</b>		17. INFORMANT <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>331 X</b> <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-22-1962</b> to <b>January 19, 1962</b> , that (I) (we) last saw the deceased alive on <b>1-22-1962</b> and that death occurred at <b>9A</b> a.m., from the causes and on the date stated above.							
22a. SIGNATURE <b>C. R. MacDonald MD</b>				22b. DATE SIGNED <b>2-1-62</b>			
22c. PHYSICIAN'S NAME (Type) <b>C. R. MacDonald</b>				22d. ADDRESS <b>204 Calverly S.W. Glen Burnie MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/29/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Balto. 25, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Homes 130 E. Fort Ave.</b>				25a. REC'D BY REGISTRAR <b>FEB 1 '62</b>			
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00116

## CERTIFICATE OF DEATH

Items 4 & 8, telephone call 1/18/62, cag

00114

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundle Co</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green Bummie</u> <span style="float: right;">c. LENGTH OF STAY IN lb</span> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RT-1-Box 285</u> <span style="float: right;">X <u>Salley</u></span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <u>RT-1 Box 285</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>ALEXANDER</u>				<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>12</u> , Year <u>1962</u>			
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>col</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Mar -15, 1894</u>	
<b>9. AGE</b> (In years last birthday) <u>67</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>In Manual</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Levin Cornish</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u>		<b>16. SOCIAL SECURITY NO.</b> <u>WV-11</u>		<b>17. INFORMANT</b> <u>Mary E. Cornish - some</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Ellen Franklin</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CARDIAC DECOMPENSATION</u> DUE TO (b) <u>DIABETES MELLITUS</u> DUE TO (c) <u>ARTERIOSCLEROTIC CORONARY HEART</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>none</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>SEPT 5, 1950</u> <b>to</b> <u>JAN 12, 1962</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>JAN 9, 1962</u> , <b>and that death occurred at</b> <u>4 P.M.</u> , <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>R. M. McLaughlin</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>1/13/62</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>R. M. McLaughlin</u>				<b>22d. ADDRESS</b> <u>3708 Mountain Rd Pasadena Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1-18-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore Nat.</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Baltimore Md</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Choy O. Wilson</u>				<b>25a. REC'D BY REGISTRAR</b> <u>18 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>William S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

001114

001113

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00117

00115

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shadyside</i>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <i>1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A. A. General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John H. Crowner</i>		4. DATE OF DEATH <i>Jan. 1 1962</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-5-1895</i>
9. AGE (In years last birthday) <i>66</i> yrs.		10. IF UNDER 1 YEAR: Months <i>1</i> Days <i>1</i> IF UNDER 24 HRS. Hours <i>1</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County or State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles H. Crowner</i>		14. MOTHER'S M maiden name <i>Oda Thompson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>W.D.</i>	
17. INFORMANT <i>Helen Crowner</i>		Address <i>Shadyside Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of lung</i> DUE TO (b) <i>Carcinoma of lung</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 163X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <i>Two weeks</i> <i>unknown</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>December 15, 61</i> to <i>Jan 1, 62</i> , that (I) (we) last saw the deceased alive on <i>Dec 31, 1961</i> , and that death occurred at <i>2 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Willard F. Smith</i> M.D.		22b. DATE SIGNED <i>1/1/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>WILLARD F. SMITH, MD</i>		22d. ADDRESS <i>Shady Side, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>1-4-1962</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Matthews</i>	23d. LOCATION (City, town or county) (State) <i>Shadyside Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i>		25a. REC'D BY REGISTRAR <i>1/1/62</i> 25b. REGISTRAR'S SIGNATURE <i>Arthur J. Thomas</i>	

7199

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00118

## CERTIFICATE OF DEATH

00116

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Anne Arundel</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X <u>RURAL - Edgewater</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>Rt-2, Pinewood</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <div style="text-align: center; font-size: 24pt;">BABY</div>				<b>4. DATE OF DEATH</b> Last <u>Jan</u> <span style="float: right;">Month <u>January</u> Day <u>8</u> Year <u>19 62</u></span>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Jan. 8, 1962</u>		<b>9. AGE</b> (In years last birthday) <u>1</u> <u>55</u> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> None		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>			
<b>13. FATHER'S NAME</b> <u>Alton Joseph Davis</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Ann Elizabeth Hatcher</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT</b> <u>Hospital records</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>prematurity</u> DUE TO (b) <u>77 6X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> <u>Jan. 8, 1962</u>		<b>20g. (County)</b> <u>Jan. 8, 1962</u>		<b>20h. (State)</b> <u>XX</u>			
<b>21. I certify</b> that (I) <u>physician</u> attended the deceased from <u>Jan. 8, 1962</u> to <u>Jan. 8, 1962</u> that (I) <u>we</u> last saw the deceased alive on <u>Jan. 8, 1962</u> , and that death occurred at <u>6:25 AM</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Niel H. Sims</u>		<b>22b. DATE SIGNED</b> <u>1/8/62</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Niel H. Sims</u>			
<b>22d. ADDRESS</b> <u>95 Cathedral St., Annapolis, Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>1-9-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>HILLCREST MEM.</u>			
<b>23d. LOCATION</b> (City, town or county) <u>ANNAPOLIS MD.</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>JOHN M. TAYLOR SONS</u>		<b>24b. ADDRESS</b> <u>ANNAPOLIS MD.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE JAN 10 '62</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Evans</u>							

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00119 CERTIFICATE OF DEATH 00117

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>2 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>Rt-2, Pinewood</b>	
3. NAME OF DECEASED (Type or print) <b>BABY</b>		4. DATE OF DEATH <b>January 8 1962</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <b>Jan. 8, 1962</b>		9. AGE (In years last birthday) yrs. <b>1</b> Min. <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Alton Joseph Davis</b>		14. MOTHER'S MAIDEN NAME <b>Ann Elizabeth Hatcher</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>prematurely</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(the deceased)</del> attended the deceased from <b>Jan. 8, 1962</b> to <b>Jan. 8, 1962</b> , that (I) <del>(the deceased)</del> last saw the deceased alive on <b>Jan. 8, 1962</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>1/8/62</b>	
22a. SIGNATURE <b>Niel H. Sims</b>		22c. PHYSICIAN'S NAME (Type) <b>Niel H. Sims</b>	
22d. ADDRESS <b>95 Cathedral St., Annapolis, Md.</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-9-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST MEM.</b>		23d. LOCATION (City, town or county) (State) <b>ANNAPOLIS MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M. TAYLOR, SONS ANNAPOLIS MD.</b>		25a. REC'D BY REGISTRAR <b>10 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		25c. ADDRESS	

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00117

00119

James Arnold

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00120

## CERTIFICATE OF DEATH

00118

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>James B. Dawson</u>				4. DATE OF DEATH Month <u>January</u> Day <u>5</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 4 - 1895</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>66</u> Days <u>66</u>	IF UNDER 24 HRS. Hours <u>66</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery Store -</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK DAWSON</u>				14. MOTHER'S MAIDEN NAME <u>SALLY BASS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes. W. WI 1917-1919</u>				16. SOCIAL SECURITY NO. <u>578-23-4638</u>			
17. INFORMANT <u>Hester A. Dawson</u>				Address <u>Churchton Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420</u> DUE TO <u>Coronary thrombosis &amp;c myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (b) <u>myocardial infarction</u> (c) <u>myocardial infarction</u> DUE TO <u>myocardial infarction</u> cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>420</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>July 7, 1961</u> to <u>Jan 5, 1962</u> that (I) <u>(was)</u> last saw the deceased alive on <u>Nov 7, 1961</u> and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.				22a. SIGNATURE <u>Willard F. Smith</u> M.D.			
22c. PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>				22d. ADDRESS <u>Shady Side, Md.</u>		22b. DATE SIGNED <u>1/5/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Jan. 9-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 9 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

00120

James B. Dawson  
Charleston

Charleston

00117

James B. Dawson  
January 2, 1872

Made note

January 2, 1872

FRANK DAWSON

FRANK DAWSON  
1872-1873

Correspondence  
information

WILLIAM F. SMITH, MD  
1/1/72

James B. Dawson  
1872-1873

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00121  
00119

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 21 yrs. 10 mo.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Airy		10X-2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last James Edward Dotson				4. DATE OF DEATH Month Day Year 1 4 1962			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1921		9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roscoe Dotson				14. MOTHER'S MAIDEN NAME Lillian ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Influenza 481 481X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome assoc. with Convulsive Disorder and Mental Deficiency, Severe						INTERVAL BETWEEN DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. - - - 19 - - -		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/12, 1940, to 1/4, 1962, that (I) (we) last saw the deceased alive on 1/4, 1962, and that death occurred at 12:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Hedward Heald Reissmann M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/5/62	
22c. PHYSICIAN'S NAME (Type) Dr. Hilda Reissmann				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 1-9-62		23b. DATE THEREOF 1-9-62		23c. NAME OF CEMETERY OR CREMATORY 12107 Md.		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. - Anna. Md.				25a. REC'D BY REGISTRAR DATE JAN 11 '62		25b. REGISTRAR'S SIGNATURE William S. Evans	

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00121

00121

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00130

CERTIFICATE OF DEATH

00130

NO

NO

Attest

W. B. Smith

Edward

W

3-1-6

James B. Smith

James F. Thompson

James B. Smith

James B. Smith

James B. Smith

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
00123 Item 1 Film G305 2/5/62 iwk													
00121													
1. PLACE OF DEATH a. COUNTY AA. Annapolis, MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY AA.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Tracys Landing, AA Co.							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital						d. STREET ADDRESS 1							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print) Helen		First Middle Last Easton		4. DATE OF DEATH Feb. 27 1962		Month Day Year							
5. SEX F.		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-10-1893		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Joseph Young				14. MOTHER'S MAIDEN NAME Barbara Holt									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give number or date of service)				17. INFORMANT Address Richard Easton, Tracys Landing, AA Co.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart failure due to Arteriosclerotic Hypertensive-Cardio-Vascular disease. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1-5-1962 to 1-27-1962, that (I) (we) last saw the deceased alive on 1-27-62 1962, and that death occurred at 1 P.M. from the causes and on the date stated above.													
22a. SIGNATURE R. L. Richardson				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-27-62							
22c. PHYSICIAN'S NAME (Type) R. L. Richardson, M.D.				22d. ADDRESS 110 Clay Street, Annapolis, Maryland									
23a. (BURIAL) CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 2-30-62		23c. NAME OF CEMETERY OR CREMATORY Bethel Way Of Cross		23d. LOCATION (City, town or county) Huntingtown, Md							
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rinkney E. Sewell, Prince Fred.				25a. REC'D BY REGISTRAR DATE 1 '62		25b. REGISTRAR'S SIGNATURE Arthur E. Hume							

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Government and other documents  
of the United States

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CERTIFICATE OF DEATH

00154

00153

Blank certificate form with horizontal lines for text entry.


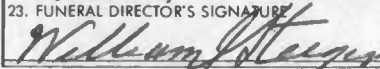



## CERTIFICATE OF DEATH

Reg. Dist. No.

00123

00125

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G. Meade</b>		c. LENGTH OF STAY IN lb <b>22½ Hrs</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jessup</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>KIMBROUGH ARMY HOSPITAL</b>						d. STREET ADDRESS <b>Box 288</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First <b>DEANDA</b>			Middle <b>DENISE</b>			Last <b>ENGLISH</b>		
4. DATE OF DEATH		Month <b>JANUARY</b>		Day <b>28</b>		Year <b>19 62</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> - DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>27 Jan 1962</b>		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min <b>22 30</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Dallas Crowe English III</b>						14. MOTHER'S MAIDEN NAME <b>Delores Ann Dunning</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>				16. SOCIAL SECURITY NO. <b>-</b>		INFORMANT <b>Mother</b>			Address <b>Box 288 Jessup, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hyaline membrane disease</b> <b>773.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Prematurity</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>19 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Jessup</b>		(County) (State)	
21. I certify that I attended the deceased from <b>27 Jan</b> , 19 <b>62</b> , to <b>28 Jan</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>28 Jan 62</b> , 19 <b>62</b> , and that death occurred at <b>7:50 P</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>28 Jan 62</b>											
ACTUAL SIGNATURE 				M.D. <b>Kimbrough Army Hospital</b>							
PHYSICIAN'S NAME (Type) <b>T. A. COOK JR., M.D.</b>				Fort George G. Meade, Md.							
22a. DATE OF CREMATION, REMOVAL (Specify) <b>1-30-62</b>				22b. DATE THEREOF <b>1-30-62</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Fort George G Meade</b>			
22d. LOCATION (City, town, or county) <b>Md</b>				22e. LOCATION (City, town, or county) <b>Md</b>				22f. LOCATION (City, town, or county) <b>Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE 				ADDRESS <b>Kimbrough Army Hospital</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 31 '62</b>			
24b. REGISTRAR'S SIGNATURE 											

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1945

COMMUNICATIONS SECTION

1945



TO: [illegible] FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

TIME: [illegible]

LOCATION: [illegible]

CHARACTER: [illegible]

CLASSIFICATION: [illegible]

REMARKS: [illegible]

REFERENCE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the Medical Director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

Items 20-21 File 305  
1-12-62 ams

00126

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00124

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North Linthicum</b>		c. LENGTH OF STAY IN 1b <b>5 Minutes</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pond off of Nursery Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North Linthicum</b>	
3. NAME OF DECEASED (Type or print) <b>James Frederick Evans, Jr.</b>		4. DATE OF DEATH <b>Jan. 1, 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 9, 1950</b>
9. AGE (In years last birthday) <b>11</b> yrs.		10. IF UNDER 1 YEAR: Months <b>11</b> Days <b>1</b> Hours <b>1</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Freddy J. Evans</b>	
14. MOTHER'S MAIDEN NAME <b>Katherine Blevins</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Mr. F. J. Evans, same as 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>929.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>929.8</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was walking on ice - when the ice broke - and he fell through</b>	
20c. TIME OF INJURY Month, Day, Year <b>1/1 1962</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Pond</b>		20f. (City or town) <b>Off Old Annapolis Rd. A.A. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gusman N. Pauchon</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 1/1/62 DATE SIGNED	
EXAMINER'S NAME (Type) <b>G. H. Faubert, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5 JAN 1962</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NATIONAL Cem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b> (State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping &amp; Kirkley Funeral Home - Glen Burnie</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 4 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Funes</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Gibson Island</b> c. LENGTH OF STAY IN 1b <b>12 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Gibson Island Country School</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> d. STREET ADDRESS <b>413 Magnolia Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Marie</b> Last <b>Fetsch</b>						4. DATE OF DEATH Month <b>Jan.</b> Day <b>30</b> Year <b>1962</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>SEPARATE</b>		8. DATE OF BIRTH <b>July 16, 1920</b>		9. AGE (In years last birthday) <b>41</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>10</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PBX Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>				11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Joseph Rainey</b>						14. MOTHER'S MAIDEN NAME <b>Emma Akers</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes give number or date of service)		17. INFORMANT <b>Harry E. Wright</b>				Address <b>Same as 2d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>773.1</b> <b>Suffocation by carbon Monoxide</b> IMMEDIATE CAUSE (a) <b>773.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>773.1</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>Found</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature and location of injury) <b>end through the back seat. By fastening one end of a hose to the exhaust pipe and the other</b>							
20c. TIME OF INJURY Month <b>1</b> Day <b>30</b> Year <b>1962</b> Hour a.m. <b>1</b> p.m. <b>30</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>In automobile</b>		20f. (City or town) <b>Pasadena</b>		(County) <b>A.A.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Gustave H. Faubert M.D.</b>						DATE SIGNED <b>1-31-62</b>					
EXAMINER'S NAME (Type) <b>Gustave H. Faubert M.D.</b>						Address (Street, city, town, or county) <b>Glen Burnie, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2-2-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>				22d. LOCATION (City, town, or country) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR <b>Hopping &amp; Kirkley</b>						24a. REC'D BY REGISTRAR <b>Feb 5 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			





## CERTIFICATE OF DEATH

Reg. Dist. No. 00126

1. PLACE OF DEATH a. COUNTY <u>ALCO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>ALCO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>600 Delaware av</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George m</u> First <u>Fisher</u> Middle Last		4. DATE OF DEATH <u>January</u> Month <u>24-1962</u> Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 14-1882</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Kennett NC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Fisher</u>		14. MOTHER'S MAIDEN NAME <u>Hawthorne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>238-03-4607</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive Heart failure</u> DUE TO (b) <u>A. S. C. U. D.</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/21</u> , 19 <u>62</u> , to <u>8/24</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>1/24</u> , 19 <u>62</u> , and that death occurred at <u>11 A</u> .M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Ernest A. Leipold</u> M.D.			
PHYSICIAN'S NAME (Type) <u>ERNEST A. LEIPOLD, MD. - 425 S.B. Ritchie Hwy- Glen Burnie, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan 27-62</u>	<u>Sharon County</u>	<u>Charlottesville NC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold A. Fink Glen Burnie Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 26 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fink</u>	

Page 4

PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The physician, medical or attending physician, may be retained to sign the certificate.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1912

(M)

Attest: \_\_\_\_\_  
Registrar of Deaths

Witness: \_\_\_\_\_  
Minister of the Gospel

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. Page 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00129

00127

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>		d. STREET ADDRESS <b>111 Smith Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Jesse A FISHER</b>				4. DATE OF DEATH Month Day Year <b>January 11 19 62</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 4, 1886</b>	
9. AGE (In years last birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLUMBER (Ret)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.N. Academy</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>CHARLES H FISHER</b>				14. MOTHER'S MAIDEN NAME <b>FLORENCE GRAY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>-</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Mrs Paul C. Dunleavy</b> Address <b>(2)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Arteriosclerotic C.V. Disease</b> DUE TO <b>E Hypertension</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>Yes</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>RECEIVED</b> attended the deceased from <b>1/9/62</b> to <b>Jan. 11, 1962</b> , that (I) <b>last</b> saw the deceased alive on <b>Jan. 11, 1962</b> , and that death occurred at <b>10:40 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Maurice Klawans</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/12/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Maurice Klawans, M.D.</b>				22d. ADDRESS <b>31 Southgate Ave., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 14-1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cent</b>		23d. LOCATION (City, town or county) (State) <b>Annapolis Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Saylor Sons</b> <b>Annapolis Md.</b>				25a. REC'D BY REGISTRAR <b>DATE JAN 16 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

00127

CERTIFICATE OF DEATH

00128

Anna (Abundant)



1900

State of New York

County of New York

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TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

51

VR A15 (4)  
ISM 7/61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00130

00128

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. NAVAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Arthur Frederick FOLZ</b>				4. DATE OF DEATH Month <b>JAN</b> Day <b>18</b> Year <b>1962</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>29 JUL 1891</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USN RET</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. N</b>		11. BIRTHPLACE (County & State, or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Frederick FOLZ</b>				14. MOTHER'S MAIDEN NAME <b>Susana KIRKHAM</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>29 yrs</b>		17. INFORMANT <b>CAPT READ, 81 Franklin St., Anna. Md.</b> <b>(D) Dorothy JACK, Balboa Hts. C. Zone</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured Aortic Aneurysm.</b> <b>RUPTURED AORTIC ANEURYSM</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1530 18 JAN., 1962</b> , to <b>18 JAN., 1962</b> , that (I) (we) last saw the deceased alive on <b>18 JAN 62</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert D. Belsh</b>				22b. DATE SIGNED <b>19 JAN 1962</b>			
22c. PHYSICIAN'S NAME (Type) <b>Robert D. BELSKI</b>				22d. ADDRESS <b>U.S. NAVAL HOSPITAL, ANNA, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-23-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arhington National</b>		23d. LOCATION (City, town or county) (State) <b>Arhington VA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Layton</b>				25a. REC'D BY REGISTRAR <b>JAN 23 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

MEDICAL CERTIFICATION

2

1

RECEIVED

UNITED STATES DEPARTMENT OF THE INTERIOR

00180

RECEIVED

00180

(M)

TO THE SECRETARY OF THE INTERIOR  
FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report.]

[Illegible text continues, including what appears to be a signature and date at the bottom.]



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

<div>1</div> <div>00131</div> <div>00129</div>											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY						a. STATE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						b. COUNTY					
c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
5. SEX						6. COLOR OR RACE					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>						8. DATE OF BIRTH					
9. AGE (In years last birthday)						IF UNDER 1 YEAR					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (County & State, or foreign country)						12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.					
17. INFORMANT						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia											
DUE TO (b) Dehydration and Senility											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Myocardial Infarct - Chronic Brain Syndrome due to Cerebral Arterio											
19. WAS AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Sclerosis											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 5/5, 1960 to 1/25, 1962, that (I) (we) last saw the deceased alive on 1/25, 1962, and that death occurred at 3:45 P.M. from the causes and on the date stated above.											
22a. SIGNATURE											
22b. DATE SIGNED 1/25/62											
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. d. Crownsville State Hospital, Maryland											
23a. BURIAL, CREMATION, or other disposal (Specify) Burial 1/30/62											
23b. DATE THEREOF											
23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. Balto. Md.											
23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR'S SIGNATURE											
25a. REC'D BY REGISTRAR											
25b. REGISTRAR'S SIGNATURE											
DATE JAN 30 '62											



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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00132

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00130

1. PLACE OF DEATH a. COUNTY <i>D. D.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>D. D.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>Edgewater Md. x</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cal. General Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Josephine</i> First <i>Fuller</i> Middle Last		4. DATE OF DEATH Month <i>1</i> Day <i>14</i> Year <i>1962</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-26-1908</i>
9. AGE (In years last birthday) <i>53</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Williams</i>		14. MOTHER'S MAIDEN NAME <i>Agnes Green</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>William Fuller</i> Address <i>Edgewater Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetic Acidosis and Coma</i> <i>260X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Unregulated Diabetes Mellitus</i> DUE TO (c) <i>Hypertensive Sclerotic Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>6 months</i> <i>10 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>February 12, 1957</i> to <i>January 14, 1962</i> that (I) (we) last saw the deceased alive on <i>January 14, 1962</i> , and that death occurred at <i>10p</i> PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Theodore H. Johnson</i>		22b. DATE SIGNED <i>1/15/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>Theodore H. Johnson, M. D.</i>		22d. ADDRESS <i>20 Dean Street, Annapolis, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-17-1962</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Davidsonville</i>		23d. LOCATION (City, town, or county) (State) <i>Davidsonville Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese Jr.</i> ADDRESS <i>Annapolis Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 17 '62</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanks</i>	

CERTIFICATE OF DEATH

00132

00132



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 12 & 14 Film G306 2/6/62 iwk

CERTIFICATE OF DEATH

00131

Reg. Dist. No.

00133

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Oakwood Road</b>				d. STREET ADDRESS <b>1 Oakwood Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHRISTINA MAGDALENA FUNKE</b>				4. DATE OF DEATH Month Day Year <b>Jan 26 1962</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-23-1882</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Austria</b>		11. BIRTHPLACE (State or foreign country) <b>Austria</b>	
13. FATHER'S NAME <b>Joseph Kauten</b>				14. MOTHER'S MAIDEN NAME <b>Dorothea unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Walter Funke</b>				Address <b>Route 1 Box 34 Glen Burnie, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420</b> DUE TO <b>Coronary artery disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis general</b> DUE TO (c) <b>Arteriosclerosis general</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Undetermined</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid arthritis general</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Baltimore, Md.</b>				20g. (County) <b>Baltimore</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Nov. 1961</b> to <b>Jan 26 1962</b> , that I last saw the deceased alive on <b>Jan 12 1962</b> , and that death occurred at <b>10P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>102 Bd A Blvd. N.E.</b> DATE SIGNED <b>Jan 26 1962</b>							
ACTUAL SIGNATURE <b>Joseph Taler, M.D.</b>				DATE SIGNED <b>Jan 26 1962</b>			
PHYSICIAN'S NAME (Type) <b>JOSEPH TALER, M.D.</b>				ADDRESS <b>Glen Burnie, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 29, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc.</b>				ADDRESS <b>1217 St. Paul St.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 31 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

(I)

(M)

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>1880</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Engineer</i>		7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>	
9. DATE OF DEATH <i>1925</i>		10. TIME OF DEATH <i>10:00 AM</i>		11. PLACE OF DEATH <i>Home</i>		12. SIGNATURE OF DECEASED <i>John J. Brown</i>	
13. SIGNATURE OF WITNESSES <i>John J. Brown</i>		14. SIGNATURE OF DECEASED <i>John J. Brown</i>		15. SIGNATURE OF DECEASED <i>John J. Brown</i>		16. SIGNATURE OF DECEASED <i>John J. Brown</i>	
17. SIGNATURE OF DECEASED <i>John J. Brown</i>		18. SIGNATURE OF DECEASED <i>John J. Brown</i>		19. SIGNATURE OF DECEASED <i>John J. Brown</i>		20. SIGNATURE OF DECEASED <i>John J. Brown</i>	
21. SIGNATURE OF DECEASED <i>John J. Brown</i>		22. SIGNATURE OF DECEASED <i>John J. Brown</i>		23. SIGNATURE OF DECEASED <i>John J. Brown</i>		24. SIGNATURE OF DECEASED <i>John J. Brown</i>	
25. SIGNATURE OF DECEASED <i>John J. Brown</i>		26. SIGNATURE OF DECEASED <i>John J. Brown</i>		27. SIGNATURE OF DECEASED <i>John J. Brown</i>		28. SIGNATURE OF DECEASED <i>John J. Brown</i>	
29. SIGNATURE OF DECEASED <i>John J. Brown</i>		30. SIGNATURE OF DECEASED <i>John J. Brown</i>		31. SIGNATURE OF DECEASED <i>John J. Brown</i>		32. SIGNATURE OF DECEASED <i>John J. Brown</i>	
33. SIGNATURE OF DECEASED <i>John J. Brown</i>		34. SIGNATURE OF DECEASED <i>John J. Brown</i>		35. SIGNATURE OF DECEASED <i>John J. Brown</i>		36. SIGNATURE OF DECEASED <i>John J. Brown</i>	
37. SIGNATURE OF DECEASED <i>John J. Brown</i>		38. SIGNATURE OF DECEASED <i>John J. Brown</i>		39. SIGNATURE OF DECEASED <i>John J. Brown</i>		40. SIGNATURE OF DECEASED <i>John J. Brown</i>	
41. SIGNATURE OF DECEASED <i>John J. Brown</i>		42. SIGNATURE OF DECEASED <i>John J. Brown</i>		43. SIGNATURE OF DECEASED <i>John J. Brown</i>		44. SIGNATURE OF DECEASED <i>John J. Brown</i>	
45. SIGNATURE OF DECEASED <i>John J. Brown</i>		46. SIGNATURE OF DECEASED <i>John J. Brown</i>		47. SIGNATURE OF DECEASED <i>John J. Brown</i>		48. SIGNATURE OF DECEASED <i>John J. Brown</i>	
49. SIGNATURE OF DECEASED <i>John J. Brown</i>		50. SIGNATURE OF DECEASED <i>John J. Brown</i>		51. SIGNATURE OF DECEASED <i>John J. Brown</i>		52. SIGNATURE OF DECEASED <i>John J. Brown</i>	
53. SIGNATURE OF DECEASED <i>John J. Brown</i>		54. SIGNATURE OF DECEASED <i>John J. Brown</i>		55. SIGNATURE OF DECEASED <i>John J. Brown</i>		56. SIGNATURE OF DECEASED <i>John J. Brown</i>	
57. SIGNATURE OF DECEASED <i>John J. Brown</i>		58. SIGNATURE OF DECEASED <i>John J. Brown</i>		59. SIGNATURE OF DECEASED <i>John J. Brown</i>		60. SIGNATURE OF DECEASED <i>John J. Brown</i>	
61. SIGNATURE OF DECEASED <i>John J. Brown</i>		62. SIGNATURE OF DECEASED <i>John J. Brown</i>		63. SIGNATURE OF DECEASED <i>John J. Brown</i>		64. SIGNATURE OF DECEASED <i>John J. Brown</i>	
65. SIGNATURE OF DECEASED <i>John J. Brown</i>		66. SIGNATURE OF DECEASED <i>John J. Brown</i>		67. SIGNATURE OF DECEASED <i>John J. Brown</i>		68. SIGNATURE OF DECEASED <i>John J. Brown</i>	
69. SIGNATURE OF DECEASED <i>John J. Brown</i>		70. SIGNATURE OF DECEASED <i>John J. Brown</i>		71. SIGNATURE OF DECEASED <i>John J. Brown</i>		72. SIGNATURE OF DECEASED <i>John J. Brown</i>	
73. SIGNATURE OF DECEASED <i>John J. Brown</i>		74. SIGNATURE OF DECEASED <i>John J. Brown</i>		75. SIGNATURE OF DECEASED <i>John J. Brown</i>		76. SIGNATURE OF DECEASED <i>John J. Brown</i>	
77. SIGNATURE OF DECEASED <i>John J. Brown</i>		78. SIGNATURE OF DECEASED <i>John J. Brown</i>		79. SIGNATURE OF DECEASED <i>John J. Brown</i>		80. SIGNATURE OF DECEASED <i>John J. Brown</i>	
81. SIGNATURE OF DECEASED <i>John J. Brown</i>		82. SIGNATURE OF DECEASED <i>John J. Brown</i>		83. SIGNATURE OF DECEASED <i>John J. Brown</i>		84. SIGNATURE OF DECEASED <i>John J. Brown</i>	
85. SIGNATURE OF DECEASED <i>John J. Brown</i>		86. SIGNATURE OF DECEASED <i>John J. Brown</i>		87. SIGNATURE OF DECEASED <i>John J. Brown</i>		88. SIGNATURE OF DECEASED <i>John J. Brown</i>	
89. SIGNATURE OF DECEASED <i>John J. Brown</i>		90. SIGNATURE OF DECEASED <i>John J. Brown</i>		91. SIGNATURE OF DECEASED <i>John J. Brown</i>		92. SIGNATURE OF DECEASED <i>John J. Brown</i>	
93. SIGNATURE OF DECEASED <i>John J. Brown</i>		94. SIGNATURE OF DECEASED <i>John J. Brown</i>		95. SIGNATURE OF DECEASED <i>John J. Brown</i>		96. SIGNATURE OF DECEASED <i>John J. Brown</i>	
97. SIGNATURE OF DECEASED <i>John J. Brown</i>		98. SIGNATURE OF DECEASED <i>John J. Brown</i>		99. SIGNATURE OF DECEASED <i>John J. Brown</i>		100. SIGNATURE OF DECEASED <i>John J. Brown</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00134

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00132

1. PLACE OF DEATH a. COUNTY <u>AA CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA CO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General</u>				d. STREET ADDRESS <u>310 Summer Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>D.</u> Last <u>GARNIER</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>15</u> Year <u>1962</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-07-03</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Brooklyn N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward J. Dowd</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Garvin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Henry V. Garnier</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>5 mins</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u></u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>auto accident - Severn River Bridge</u>					
20c. TIME OF INJURY Month, Day, Year <u>4:05</u> <u>1/15</u> <u>1962</u> Hour <u>g.m.</u> <u>p.m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>AA CO MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. L. H. [Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. L. H. [Signature]</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>1-19-1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor, Son</u>				24a. REC'D BY REGISTRAR <u>JAN 18 '62</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Frame</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>102 South St.</i>		d. STREET ADDRESS <i>76 Larkin St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Louise W. Giles</i>		4. DATE OF DEATH Month Day Year <i>1 21 1962</i>	
5. SEX <i>Female</i>	6. COLOR OF RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-3-1903</i>
9. AGE (In years last birthday) <i>58</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maids</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gov. Family</i>	
11. BIRTHPLACE (State or foreign country) <i>A.A. Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Millie Wilson</i>		14. MOTHER'S MAIDEN NAME <i>Ida Hammond</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>216-16-4020</i>	
17. INFORMANT Address <i>Maggie Foote - Annapolis, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of cervix with metastases</i> DUE TO (b) <i>171X</i> DUE TO (c) <i>about 20mo</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertensive Cardiovascular Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April 22, 1960</i> to <i>Jan 21, 1962</i> that (I) (we) last saw the deceased alive on <i>Jan 19, 1962</i> and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Faye W. Allen</i>		22b. DATE SIGNED <i>1/22/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>Faye W. Allen</i>		22d. ADDRESS <i>620 Cathedral St Annapolis, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-25-62</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Hopes Chapel</i>		23d. LOCATION (City, town, or county) (State) <i>Edgewater, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. - Annapolis, Md.</i>		25a. REC'D BY REGISTRAR <i>JAN 22 1962</i>	
25b. REGISTRAR'S SIGNATURE			



# 1 FOR STATE HEALTH DEPT. M X I TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is unavoidable, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 00136 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00134

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY in b <u>Since 1929</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 1 Box 290</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>James Glass</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>January 10th. 19 62</u>					
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>					
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9/6/95</u>					
<b>9. AGE</b> (In years last birthday) <u>66</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired laborer</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months Days	Hours Min.						
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Baltimore, Md.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>USA</u>					
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>George Glass</u>					
<b>14. MOTHER'S MAIDEN NAME</b> <u>Ann Margaret Herrman</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>					
<b>16. SOCIAL SECURITY NO.</b> <u>215-09-4901</u>		<b>17. INFORMANT</b> <u>Mr. Carl Glass (brother)</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> (b) <u>420.1</u> (c) <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>					
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19					
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)					
<b>20f. (City or town)</b>		<b>(County)</b>					
<b>(State)</b>		<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
<b>ACTUAL SIGNATURE</b> <u>Gustave H. Faubert, M.D.</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>					
<b>EXAMINER'S NAME</b> (Type) <u>Gustave H. Faubert, M.D.</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>13 Jan 1962</u>					
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>		<b>22d. LOCATION (City, town, or country)</b> <u>Baltimore 25 Maryland</u>					
<b>23. FUNERAL DIRECTOR</b> <u>Hopping &amp; Kirkley</u>		<b>24a. REC'D BY REGISTRAR</b> <u>JAN 15 '62</u>					
<b>ADDRESS</b> <u>Glen Burnie Md.</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Haines</u>					

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00135

00137

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>A-ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SEVERN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SEVERN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BOX 351, QUARTERFIELD RD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM JOSEPH GOEDEKE</b>		4. DATE OF DEATH Month Day Year <b>JAN. 6 1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 MARCH 1888</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLUMBER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTO., MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>YES-USA</b>	
13. FATHER'S NAME <b>HENRY GOEDEKE (dec)</b>		14. MOTHER'S MAIDEN NAME <b>NOT KNOWN (dec)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>216-05-7596</b>	
17. INFORMANT Address <b>MRS THERESA JOHNS (daughter) SAME ADDRESS</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO <b>HYPERTENSION</b> (b) <b>DIAbetes</b> DUE TO <b>DIAbetes</b> (c) <b>DIAbetes</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 yrs</b> <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MED CA. OF LUNG, REMOVED CYRS AGO</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year <b>19</b>		20d. INJURY OCCURRED <b>—</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>FEB 1960</b> to <b>PRESENT</b> , that I last saw the deceased alive on <b>4 JAN 1962</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. F. Manuzak</b> M.D.		DATE SIGNED <b>425 S. RITCHIE HWY. 6 JAN 1962</b>	
PHYSICIAN'S NAME (Type) <b>H. F. MANUZAK, M.D.</b>		<b>GLENBURNIE, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10 Jan 1962</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Brooklyn TFD, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. V. Singleton</b> ADDRESS <b>Glen Burnie Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 9 '62</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

00157

NAME OF DECEASED JANE HENRY		AGE 45		SEX F		RACE W		DATE OF BIRTH 1890		PLACE OF BIRTH BALTIMORE	
RESIDENCE 1234 E. BALTIMORE		OCCUPATION HOUSEWIFE		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		DATE OF DEATH 1935		PLACE OF DEATH HOME	
SIGNATURE OF DECEASED JANE HENRY		SIGNATURE OF WITNESS JANE HENRY		SIGNATURE OF PHYSICIAN JANE HENRY		SIGNATURE OF CLERK JANE HENRY		SIGNATURE OF REGISTRAR JANE HENRY		SIGNATURE OF JURY JANE HENRY	
DATE OF DEATH 1935		TIME OF DEATH 12:00 PM		PLACE OF DEATH HOME		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		DATE OF DEATH 1935	
NAME OF DECEASED JANE HENRY		AGE 45		SEX F		RACE W		DATE OF BIRTH 1890		PLACE OF BIRTH BALTIMORE	
RESIDENCE 1234 E. BALTIMORE		OCCUPATION HOUSEWIFE		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		DATE OF DEATH 1935		PLACE OF DEATH HOME	
SIGNATURE OF DECEASED JANE HENRY		SIGNATURE OF WITNESS JANE HENRY		SIGNATURE OF PHYSICIAN JANE HENRY		SIGNATURE OF CLERK JANE HENRY		SIGNATURE OF REGISTRAR JANE HENRY		SIGNATURE OF JURY JANE HENRY	
DATE OF DEATH 1935		TIME OF DEATH 12:00 PM		PLACE OF DEATH HOME		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		DATE OF DEATH 1935	
NAME OF DECEASED JANE HENRY		AGE 45		SEX F		RACE W		DATE OF BIRTH 1890		PLACE OF BIRTH BALTIMORE	
RESIDENCE 1234 E. BALTIMORE		OCCUPATION HOUSEWIFE		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		DATE OF DEATH 1935		PLACE OF DEATH HOME	
SIGNATURE OF DECEASED JANE HENRY		SIGNATURE OF WITNESS JANE HENRY		SIGNATURE OF PHYSICIAN JANE HENRY		SIGNATURE OF CLERK JANE HENRY		SIGNATURE OF REGISTRAR JANE HENRY		SIGNATURE OF JURY JANE HENRY	
DATE OF DEATH 1935		TIME OF DEATH 12:00 PM		PLACE OF DEATH HOME		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		DATE OF DEATH 1935	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item 9 Film G306 2/6/62 iuk

00138

00136

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>			d. STREET ADDRESS <u>1 Rt-2, Skidmore Area.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Jannie</u> Middle <u>GREENE</u> Last <u>GREENE</u>			<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>24</u> Year <u>19 62</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1887</u>	9. AGE (In years last birthday) <u>74 1/2</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Daniel Harris</u>			14. MOTHER'S MAIDEN NAME <u>Hester Hines</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>317-16-3430</u>		17. INFORMANT <u>Viola Jones - Annapolis, Md.</u> Address <u>  </u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema due to Congestive Heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Went to enter Arteriosclerosis</u> (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1/20/62</u> to <u>Jan. 23, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan. 23, 1962</u> , and that death occurred at <u>6:10 AM</u> from the causes and on the date stated above.					
22. SIGNATURE <u>R. L. Richardson</u> PHYSICIAN'S NAME (Type) <u>R. L. Richardson, M.D.</u>			22a. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. ADDRESS <u>110 Clay St., Annapolis, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-28-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Stevensville Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Stevensville, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Backell - Easton, Md.</u>			25a. REC'D BY REGISTRAR DATE <u>FEB 2 '62</u>		
			25b. REGISTRAR'S SIGNATURE <u>William S. Hanna</u>		

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00139

## CERTIFICATE OF DEATH

00137

1. PLACE OF DEATH a. COUNTY <b>ANNE Arundel Co.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4104 Ritchie Hwy.</b>				d. STREET ADDRESS <b>404 Ritchie Hwy</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Webster</b>		First <b>W.</b> Middle <b>Griebel</b> Last		4. DATE OF DEATH <b>1 3 19 62</b>		Month <b>1</b> Day <b>3</b> Year <b>19 62</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-30-94</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>67</b> Days		IF UNDER 24 HRS. Hours <b>67</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hotel Manager</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ind.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Ind.</b>							
13. FATHER'S NAME <b>Chas. G.</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Hiatt</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Family</b> Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Degeneration</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis</b> (e), stating the underlying cause last. (c) <b>Diabetes Mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b> <b>2 yrs.</b> <b>5 yrs.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-1</b> to <b>1-3</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>1-3</b> , 19 <b>62</b> and that death occurred at <b>7 A.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A.C. SOLLOD</b>				22b. DATE SIGNED <b>1-3-62</b>			
22c. PHYSICIAN'S NAME (Type) <b>A.C. SOLLOD</b>				22d. ADDRESS <b>707 E. Fort Ave. Balto. 30, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/6/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Locusts</b>		23d. LOCATION (City, town or county) (State) <b>Balto.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Homes 130 E. Fort Ave. #30 jhh</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 5 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00140

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00138

1. PLACE OF DEATH a. COUNTY <u>DON ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE <u>N. C.</u> b. COUNTY <u>ALLEN?</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis - M.S.</u>		c. LENGTH OF STAY IN 1b <u>5 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Roseborough -</u>		70X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DON ANNIE ARUNDEL HOSP.</u>				d. STREET ADDRESS <u>UNKNOWN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lemey</u> Middle <u>C</u> Last <u>HALL</u>				4. DATE OF DEATH Month <u>1</u> Day <u>15</u> Year <u>1962</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-4-89</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAVAL YARD</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES HALL</u>				14. MOTHER'S MAIDEN NAME <u>CELONA FAIRCLOTH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>244109009</u>		17. INFORMANT <u>MRS. OLA MINTZ - Rt 1 Box 135 - SEVERNA PARK, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac</u> DUE TO <u>4-4-4</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. L. Wharff</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. L. Wharff, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-18-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Baptist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>ROSEBORO N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Baranco</u>				24a. REC'D BY REGISTRAR <u>JAN 18 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00141

00139

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>10 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>Edgewater</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ruth NUTTER HALL</b>				4. DATE OF DEATH Month Day Year <b>January 4 19 62</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 4, 1904</b>	
9. AGE (In years last birthday) <b>57 yrs.</b>		10. KIND OF BUSINESS OR INDUSTRY <b>School Teacher</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Melvin M.D. Nutter</b>				14. MOTHER'S MAIDEN NAME <b>Carrie D. Derrickson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214 38 0388</b>		17. INFORMANT <b>Hospital records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ac. Purulent Pericarditis</b> DUE TO (b) <b>embolism Arteriam</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Rheumatic Heart disease, Mitral &amp; Aortic Stenosis, Aortic Aneurysm</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (doctored) attended the deceased from <b>Dec. 24, 1961</b> to <b>Jan. 3, 1962</b> , that (I) <b>did</b> last saw the deceased alive on <b>Jan 3, 1962</b> , and that death occurred at <b>5:30 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Maurice Klawans</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/5/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Maurice Klawans</b>				22d. ADDRESS <b>31 Southgate Ave., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 7, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Memorial</b>		23d. LOCATION (City, town or county) (State) <b>Annapolis, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>				25a. REC'D BY REGISTRAR <b>JAN 8 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krawns</b>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 is to be retained by the hospital or attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00142

## CERTIFICATE OF DEATH

00140

1. PLACE OF DEATH a. COUNTY <b>Maryland</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena P.O.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena P.O.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>47 Woodholme Circle</b>		d. STREET ADDRESS <b>47 Woodholme Circle</b>	
3. NAME OF DECEASED (Type or print) <b>John R. Hillary</b>		4. DATE OF DEATH Month Day Year <b>JAN 8 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12, 1883</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired- Structural steel worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Thomas Hillary</b>		14. MOTHER'S MAIDEN NAME <b>Mary Rieter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-03-1208</b>	
17. INFORMANT <b>Mrs. Nellie G. Hillary</b>		Address <b>47 Woodholme Circle</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASC. DISEASE</b> DUE TO (c) <b>4 YEARS</b> INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4 20.1</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>APRIL 1958</b> to <b>JAN 1962</b> that (I) (we) last saw the deceased alive on <b>DEC 5 1961</b> , and that death occurred <b>9:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Arthur Lankford Jr.</b>		22b. DATE SIGNED <b>1-8-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR LANKFORD JR.</b>		22d. ADDRESS <b>MOUNTAIN RD. PASADENA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-11-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Woodlawn Md.</b>
24 FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Jackson &amp; Son</b>		25a. REC'D BY REGISTRAR <b>JAN 10 1962</b>	
ADDRESS <b>Baltimore 17, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Wm J. Jackson</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
05345									
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Laurel, Md.</b> c. LENGTH OF STAY in 1b <b>3yr.11 mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>District Training School Children's Center</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington, D.C.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>648 Kenilworth Terrace N.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Sandra Jean Hillman</b>			4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>1962</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/9/53</b>		9. AGE (In years last birthday) <b>8</b> yrs. IF UNDER 1 YEAR: Months <b>8</b> Days <b>8</b> IF UNDER 24 HRS.: Hours <b>8</b> Min. <b>8</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Institutionalized</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Lee Hillman</b>					14. MOTHER'S MAIDEN NAME <b>Ruth Geneva Marshall</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>			16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Children's Center, Laurel, Md.</b> Address <b>---</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration - pneumonia</b> <b>325.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Mental retardation</b> (a), stating the underlying cause last. (c) <b>Inanition</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arrested pulmonary tuberculosis</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>2/28/58</b> 19 <b>58</b> to <b>1/22/62</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>1/22/62</b> 19 <b>62</b> , and that death occurred at <b>6:45 am</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Margaret W. Mola</b> M.D.					22b. DATE SIGNED <b>Jan. 22, 1962</b>		22c. PHYSICIAN'S NAME (Type) <b>Margaret W. Mola, M.D.</b>		
22d. ADDRESS <b>Children's Center, Laurel, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>1-25-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DTS cemetery</b>		23d. LOCATION (City, town or county) (State) <b>DTS Laurel, Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Swales Ant Vent Admin</b> ADDRESS <b>---</b>					25a. REC'D BY REGISTRAR DATE <b>MAY 31 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		

003415

CELESTIAL NAVIGATION

January 1941

THE UNIVERSITY OF CHICAGO  
DEPARTMENT OF ASTRONOMY  
CHICAGO, ILL.

RECEIVED  
JAN 10 1941

TO THE DIRECTOR  
OF THE OBSERVATORY  
FROM THE DIRECTOR  
OF THE OBSERVATORY

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be completed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00143

00141

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>1 704 Wells St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emerson</b>		First Middle Last <b>HOLLAND</b>		4. DATE OF DEATH Month Day Year <b>January 29 1962</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>January 17, 1907</b>		9. AGE (In years last birthday) <b>55 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Benjamin Holland</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Simms</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>570</b>		17. INFORMANT <b>Mr. Holland - Annapolis, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>527.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Branch - Pneumonia</b> (c) <b>Exhaustion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from <b>Jan. 29, 1962</b> , to <b>Jan. 29, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan. 29, 1962</b> , and that death occurred at <b>2:00 AM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Aris T. Allen, M.D.</b>	
22b. DATE SIGNED <b>2:00 AM</b>		22c. PHYSICIAN'S NAME (Type) <b>Aris T. Allen, M.D.</b>		22d. ADDRESS <b>62 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-2-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Annapolis Neck</b>	
23d. LOCATION (City, town or county) <b>Annapolis, Md.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, Jr. - Annapolis, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 30 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Brand</b>		25c. REGISTRAR'S NAME <b>Arthur S. Brand</b>		25d. REGISTRAR'S ADDRESS <b>Annapolis, Md.</b>	



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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00144

00142

1X  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>708 Biddle Road</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> d. STREET ADDRESS <b>708 Biddle Rd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LOLA MAE HOOD</b>		4. DATE OF DEATH <b>June 7 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1942</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dental Ass't</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Dentist</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Dorice Hood</b>		14. MOTHER'S MAIDEN NAME <b>Norma Strieb</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Glen Burnie, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO (b) <b>729.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>729.0</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Epilepsy (Clinical)</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Drowned in bath tub - Most likely due to epileptic seizure</b>	
20c. TIME OF INJURY Month, Day, Year <b>3:30 p.m. 1 7 1962</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Glen Burnie A. Arundel Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S Fisher</b>		DATE SIGNED <b>1-8-62</b>	
EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/10/62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>		22d. LOCATION (City, town, or country) (State) <b>Glen Burnie, Md.</b>	
23. FUNERAL DIRECTOR <b>Hopping and Kirkley, Glen Burnie, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>ANN 9 '62</b>	

Serial

00100



700 State St. W.

700 State St. W.

June 22, 1902

June 22, 1902

U.S.A.

Mr. James Ferry, 507 Kent Circle

Mr. James Ferry, 507 Kent Circle

Respectfully,  
Your obedient servant,  
John D. H. H. H.

cc  
Mr. James Ferry  
507 Kent Circle  
St. Louis, Mo.

Enclosed is a check for \$10.00, and to collect the same.

Very truly yours,  
John D. H. H. H.

John D. H. H. H.

1-1-12

Hopping and Wicker, John D. H. H. H.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00145

00143

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ferndale</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1523 Tieman Circle</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ferndale</b> d. STREET ADDRESS <b>1523 Tieman Circle</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Samuel Edwin Hopkins</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>26</b> Year <b>1962</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 6, 1884</b>	9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Revere Brass &amp; Copper</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Annapolis, Md.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Edward Hopkins</b>		14. MOTHER'S MAIDEN NAME <b>Florence Brooks</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>I</b>		17. INFORMANT <b>Mrs. Johanna C. Hopkins</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) <b>Acute coronary occlusion</b> <b>Myocardial heart disease</b> <b>Arteriosclerosis, Old age</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Years</b> <b>Years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>March 19, 1958</b> to <b>Jan. 26, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan. 26, 1962</b> and that death occurred at <b>3:30 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Henry Armanas</b>		M.D. <b>HENRY ARMANAS</b>		22b. DATE SIGNED <b>Jan 27, 1962</b>			
22c. PHYSICIAN'S NAME (Type) <b>HENRY ARMANAS</b>		22d. ADDRESS <b>1934 Wilken ave Baltimore, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/30/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Pk. Cem.</b>	23d. LOCATION (City, town or county)	(State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tichner &amp; Sons Inc. North &amp; Po. Ave. Balt. 17, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 31 '62</b>	25b. REGISTRAR'S SIGNATURE <b>Charles S. Hanna</b>				

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)  
15M 9/60

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TO HOSPITAL OR AFTER DEATH. The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00144											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital						d. STREET ADDRESS 42 Murray Ave.					
3. NAME OF DECEASED (Type or print) Harvey R. HOWARD SR						4. DATE OF DEATH Month / Day Year 1 / 31 1962					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 17, 1884		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER-RET PLUMBER						11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME JOHN HOWARD						14. MOTHER'S MAIDEN NAME MARY AUSTIN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT Address HARVEY R. HOWARD 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Neoplasm Right Lung										INTERVAL BETWEEN ONSET AND DEATH 3 WKS.	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE 1967, to Jan. 31, 1962, that (I) (X) last saw the deceased alive on Jan. 31, 1962, and that death occurred at 7:45 AM from the causes and on the date stated above.											
22a. SIGNATURE Edward S. Beck M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/31/62			
22c. PHYSICIAN'S NAME (Type) Edward S. Beck						22d. ADDRESS 73 Franklin St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-3-1962		23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cem		23d. LOCATION (City, town or county) (State) Annapolis Md					
24. FUNERAL DIRECTOR'S SIGNATURE John M. T aylor Sues Annapolis Md						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
DATE FEB 5 '62						Arthur S. Hines					

(M)

(1)

*Orthocentrus*

*Prochilodus*

*Brevoortia*

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00147

00145

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A. A. Co.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Glen Burnie</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Arundel Gen'l Hospital</b>							
3. NAME OF DECEASED (Type or print) <b>ANNA</b>		First		Middle		Last	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 12-1889</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Pollard</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>George Flutchko - 316 4th Ave.</b>		Address <b>Glen Burnie Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO (c) <b>15 Years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>1946</b> , <b>1946</b> to <b>Jan 28</b> , 1962 that (I) (we) last saw the deceased alive on <b>Jan 10</b> , 1962, and that death occurred at <b>1 A.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Edward J. Bennett</b>				22b. DATE SIGNED <b>1-28-62</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert P. Ware</b>	
22d. ADDRESS <b>Glen Burnie, Md.</b>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 31-1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns CATH Church Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Allegheny Co. Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Singleton Funeral Home</b>				25. REC'D BY REGISTRAR <b>DATE JAN 30 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00148

## CERTIFICATE OF DEATH

00146

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <u>Pasadena P.O., MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Pasadena, Md.</u> c. LENGTH OF STAY IN 1b <u>2 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt. 9 Box 399A</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Pasadena P.O., Md.</u> d. STREET ADDRESS <u>Rt. 9 Box 399A</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary</u> <u>Baker</u> <u>Hyman</u>				<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>30</u> Year <u>1962</u>													
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>?</u>		<b>9. AGE</b> (In years last birthday) <u>70+</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Cape Charles, Va.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>									
<b>13. FATHER'S NAME</b> <u>Jim Bell</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Smith</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Iclon Lee</u> <u>Same as #2</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>7840</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anorrhexia</u> DUE TO (c) <u>Old age</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 day</u> <u>1 week</u>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>					
<b>21. I certify that (1) (this hospital) attended the deceased from <u>29 Jan. 1962</u> to <u>30 Jan. 1962</u>, that (1) (no) last saw the deceased alive on <u>29 Jan. 1962</u>, and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above.</b>																	
<b>22a. SIGNATURE</b> <u>C. Earl Hill</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>30 Jan, 62</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>C. EARL HILL, M.D.</u>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal - 2-2-62</u>				<b>23b. DATE THEREOF</b> <u>2-2-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Plymouth</u>		<b>23d. LOCATION</b> (City, town or county) <u>North Carolina</u> (State)									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Isaiah L Brown &amp; Son</u>				<b>ADDRESS</b> <u>108 W Montgomery Street</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 5 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles L. Thomas</u>									

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00149

00147

<b>1. PLACE OF DEATH</b> a. COUNTY <u>AA Anne Arundel</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. LENGTH OF STAY IN 1b <u>18 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		d. STREET ADDRESS <u>207 Sycamore Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>207 Sycamore St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Fannie Cosire Isaac</u>				<b>4. DATE OF DEATH</b> Month <u>Jan</u> Day <u>18</u> Year <u>1962</u>			
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 1 - 1886</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry C. Roberts</u>				14. MOTHER'S MAIDEN NAME <u>Laura T. Knightor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Gordon Isaac</u> Address <u>same</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular Disease</u> (b) <u>Arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4-5 yrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/18/62</u> to <u>1/18/62</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1/18/62</u> , 19 <u>62</u> , and that death occurred at <u>8:20 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Chas. L. Ball, Jr.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/18/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Linthicum Md.</u>				22d. ADDRESS <u>Linthicum Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/22/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u>				ADDRESS <u>4600 Liberty Hghts. Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 24 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

1911

CERTIFICATE OF DEATH

00110

(M)

John C. Roberts

Age 45

Residence 1234 Main St.

Occupation Farmer

Married

Spouse Mary C. Roberts

Children 3

Death Date Jan 15, 1911

Place of Death Home

Cause of Death Heart Disease

Signature of Doctor

Signature of Family

Witness

Minister

Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00148

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN 1b <b>20 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>201 Second Ave. S.E.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Same</b> d. STREET ADDRESS <b>Same</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>S. William X. Jefferson</b>				4. DATE OF DEATH Month <b>January</b> Day <b>15th.</b> Year <b>19 62</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/14/1857</b>	
9. AGE (In years lost birthday) <b>104 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Painter's helper.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Jefferson</b>				14. MOTHER'S MAIDEN NAME <b>Nettie Clark</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-14-5206</b>		17. INFORMANT <b>Mrs. Elsie McGowan, 'daughter'</b> Address <b>Same As #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchial Asthma</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Over 3 y.</b> <b>Over 3 y.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 2 1958</b> , to <b>January 15th 62</b> that (I) (we) last saw the deceased alive on <b>Jan. 14th, 19 62</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Gustave H. Faubert, M.D.</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/16/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>				22d. ADDRESS <b>Glen Burnie, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>18th Jan. 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Howard County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Richard V. Dingle</b>				ADDRESS <b>Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 17 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>			

CERTIFICATE OF DEATH

1915

1915

1. Name of deceased: \_\_\_\_\_  
2. Sex: \_\_\_\_\_  
3. Age: \_\_\_\_\_  
4. Date of birth: \_\_\_\_\_  
5. Date of death: \_\_\_\_\_  
6. Place of death: \_\_\_\_\_  
7. Cause of death: \_\_\_\_\_  
8. Signature of physician: \_\_\_\_\_  
9. Signature of registrar: \_\_\_\_\_  
10. Date of registration: \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>2 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Annapolis</b>	
3. NAME OF DECEASED (Type or print) <b>Rachael</b> First <b>JOHNSON</b> Middle Last		4. DATE OF DEATH <b>January 12 1962</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-5-1893</b> yrs. Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Ireland</b>		14. MOTHER'S MAIDEN NAME <b>Betty Porter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Isiah Johnson Brown</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive Cardiovascular Disease years?</b> (c) <b>stroke</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>stroke</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>Isiah Johnson</b> attended the deceased from <b>Nov. 13, 1961</b> to <b>Jan. 12, 1962</b> , that (I) <b>xx</b> last saw the deceased alive on <b>Jan. 12, 1962</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Faye W. Allen</b>		22b. DATE SIGNED <b>7:30 PM</b>	
22c. PHYSICIAN'S NAME (Type) <b>Faye W. Allen, M.D.</b>		22d. ADDRESS <b>62 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-16-1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Broadneck</b>		23d. LOCATION (City, town or county) (State) <b>St. Margarets Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese</b>		25a. REC'D BY REGISTRAR <b>JAN 11 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krays</b>		25c. DATE	

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Page 2 of 2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00152

00150

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie (R.F.D.)</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Solley</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie (R.F.D.)</u> d. STREET ADDRESS <u>1 Solley</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Thomas Whitney Johnson</u>		<b>4. DATE OF DEATH</b> Month <u>Jan</u> Day <u>10</u> Year <u>1962</u>					
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>11<sup>th</sup> August 1882</u>	<b>9. AGE</b> (In years last birthday) <u>79</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u>	<b>IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Policeman (Ret.) A.A.Co. Police Dept.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>A.A.Co. Maryland</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Archibald Johnson</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Ann Warfield</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>212-28-2519</u>		<b>17. INFORMANT</b> <u>Mrs. Bertha Stinchcomb - Glen Burnie, Md.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Acute coronary Occlusion</u> <b>420.1</b> DUE TO <u>A. S. C. V. D.</u> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <b>(c)</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <u>19</u> e.m. p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>10 Jan</u>, 1962 that (I) last saw the deceased alive on <u>10 Jan</u>, 1962, and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>C. Earl Hill</u>		<b>22b. DATE SIGNED</b> <u>1/10/62</u>	<b>22c. PHYSICIAN'S NAME (Type)</b> <u>C. EARL HILL, MD</u>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>13 Jan. 1962</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cem.</u>	<b>23d. LOCATION (City, town or county)</b> <u>Brooklyn, RFD</u>	<b>(State)</b> <u>Md.</u>		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Richard V. Singleton</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JAN 12 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00153

00151

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>49</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severna Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X-Box 303 at 2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Bessie Estelle Jones</i>		4. DATE OF DEATH Month <i>1</i> Day <i>1</i> Year <i>1962</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 11, 1887</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>House</i>	
11. BIRTHPLACE (State or foreign country) <i>Bozman Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>McQuay</i>		14. MOTHER'S M maiden name <i>Faulkner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Family</i>	
17. INFORMANT <i>Family</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 443X DUE TO (b) <i>Hypertensive C.S.C.D. Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1957</i> to <i>1962</i> , that (I) (we) lost the deceased alive on <i>1-1-62</i> 19, and that death occurred at <i>1:30</i> PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert R. Holm</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Severna Park Md</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>B</i>		23b. DATE THEREOF <i>1-4-62</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cm.</i>		23d. LOCATION (City, town, or county) (State) <i>Balto 25. Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>McCully Funeral Home</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 3 '62</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			

MEDICAL CERTIFICATION

10110

CERTIFICATE OF DEATH

10110

(M)



(A)





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00154

00152

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>2 yrs. 5 mo.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>613 Sixtieth Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Jones</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>1</u> Day <u>4</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 1890</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry Holland</u>				14. MOTHER'S MAIDEN NAME <u>Julia ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> 493X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome associated with Cerebral Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>  </u>		Month, Day, Year <u>7/29</u> <u>1959</u> to <u>1/4</u> <u>1962</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>		(County) <u>  </u>		(State) <u>  </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>7/29</u> <u>1959</u> to <u>1/4</u> <u>1962</u> that (I) (we) last saw the deceased alive on <u>1/4</u> <u>1962</u> , and that death occurred at <u>11:20 p.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>L. BENEDICT M.D.</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>1/5/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>				22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1/10/62</u>		23b. DATE THEREOF <u>1/10/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Haffner Funeral Home Wash.</u>				ADDRESS <u>909-68th</u>		25. REC'D BY REGISTRAR <u>1-5-62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>							

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

JAN 9 '62

Arthur S. Hays



00154

00154

Greenwell, James Henry  
212 1/2 1st St. N. W.  
St. Paul, Minn.

Feb 10 1930

St. Paul, Minn.

Dear Sir:

I have your letter of the 10th inst.

and am sorry to hear of your

trouble.

I am sure you will get well

soon.

I am, Sir, very respectfully,

Your obedient servant,

James Henry Greenwell

St. Paul, Minn.

10/10/30

10/10/30

10/10/30

10/10/30

10/10/30

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00153

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 must be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Odenton</b>				c. LENGTH OF STAY IN 1b <b>35 y.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 28 Old Telegraph Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Peter M. Joze</b>				4. DATE OF DEATH Month Day Year <b>January 6th. 1962</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/1888</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired merchant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>			
11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WWII</b>				16. SOCIAL SECURITY NO. <b>215-34-8336</b>			
17. INFORMANT <b>Mrs. Peter M. JOze (wife)</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Diabetes</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>?</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>1/6/62</b> DATE SIGNED <b>Gustave H. Faubert, M.D.</b> EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b> Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/10/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BALTO-NATIONAL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>Fredrick Rd MD</b>	
23. FUNERAL DIRECTOR <b>Charles W. Ischaewski 637 W. Oak Rd.</b>				24. REC'D BY REGISTRAR <b>Arthur L. Harris</b>			

FOR SALE  
BRAND NEW



THE  
MILITARY  
MUSEUM  
OF  
THE  
UNITED  
STATES  
OF  
AMERICA  
WASHINGTON  
D.C.

70153

70153

MILITARY MEDICAL EXAMINER'S CERTIFICATE OF DRAIN

THE  
MILITARY  
MUSEUM  
OF  
THE  
UNITED  
STATES  
OF  
AMERICA  
WASHINGTON  
D.C.

NAME  
RANK  
COMPANY  
REGIMENT  
BATTALION  
BRIGADE  
DIVISION  
CORPS  
ARMY

DATE  
PLACE  
OFFICE

EXAMINED  
BY  
DATE  
PLACE  
OFFICE

REMARKS

SIGNED  
DATE  
PLACE  
OFFICE

APPROVED  
DATE  
PLACE  
OFFICE

RECEIVED  
DATE  
PLACE  
OFFICE

FOR  
THE  
MILITARY  
MUSEUM  
OF  
THE  
UNITED  
STATES  
OF  
AMERICA  
WASHINGTON  
D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician and completely filled in. The funeral director to FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00156

00154

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>AnneArundel General Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Pasadena</b>	
3. NAME OF DECEASED (Type or print) <b>Evelyn J. KELLY</b>		d. STREET ADDRESS <b>213 Glen Road, Riviera Beach</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 31, 1920</b>	
9. AGE (In years last birthday) <b>41 yrs.</b>		10. IF UNDER 1 YEAR Months <b>23</b> Days <b>19</b> Hours <b>62</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sportswear</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Nicholo DiMarino</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Patricia E. Kelly</b>	
17. INFORMANT <b>Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive subarachnoid hemorrhage</b> <b>296X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Idiopathic thrombocytopenic purpura</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs.</b> <b>4 1/2 years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>e.m.</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) <del>this person</del> attended the deceased from <b>Jan. 23, 1962</b> to <b>Jan. 23, 1962</b> , that (1) <del>the</del> last saw the deceased alive on <b>Jan. 23, 1962</b> , and that death occurred at <b>9:01 AM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Richard M. Paul</b> M.D.	
22b. DATE SIGNED <b>9:01 AM</b>		22c. PHYSICIAN'S NAME (Type) <b>Richard M. Paul</b>	
22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>		22e. REC'D BY REGISTRAR <b>JAN 29 '62</b>	
22f. REGISTRAR'S SIGNATURE <b>Arthur S. Krawiec</b>		22g. DATE	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 26, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town or county) (State) <b>Frederick Rd. Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Gonce</b>		4001 Ritchie Hwy. (25)	

George J. Gonce

00180





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00157

00155

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>10</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>635 Chase Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James T. LEATHERBURY</b>		4. DATE OF DEATH <b>January 10 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 14, 1879</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Leatherbury</b>		14. MOTHER'S MAIDEN NAME <b>Jenny Simons</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>MRS. JAMES T. LEATHERBURY #2</b>	
17. INFORMANT <b>MRS. JAMES T. LEATHERBURY</b>		Address <b>#2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>10 years</b> DUE TO cause listed. (c) <b>48 hours</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>Richard I. Hochman</b> attended the deceased from <b>Jan. 10, 1962</b> to <b>Jan. 10, 1962</b> , that (I) <b>Richard I. Hochman</b> last saw the deceased alive on <b>Jan. 10, 1962</b> , and that death occurred at <b>5:30 PM</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard I. Hochman</b> M.D.		22b. DATE SIGNED <b>1/11/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard I. Hochman, M.D.</b>		22d. ADDRESS <b>59 Franklin St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/13/1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARGARETS</b>		23d. LOCATION (City, town or county) (State) <b>ANNE ARUNDEL CO MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor</b> Address <b>Sons Annapolis Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 15 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Knecht</b>			

00153

CERTIFICATE OF DEATH

Name of deceased

John Doe

Name of informant

Address

Address

City

City

State

State

(M)

(1)

Signature of informant

Signature of registrar

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00158

## CERTIFICATE OF DEATH

Item 17 Film G305 1/17/62 iwk

00156

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. STREET ADDRESS <b>Circle Road, Long Point</b>	
3. NAME OF DECEASED (Type or print) <b>Edward</b>		4. DATE OF DEATH Month <b>January</b> Day <b>2</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 26, 1895</b>
9. AGE (In years last birthday) <b>66 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Poultry Dealer Self Employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Heard R. Howe</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Sokates</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) <b>Yes WWI</b>	
16. SOCIAL SECURITY NO. <b>210-12-9240</b>		17. INFORMANT <b>Carrie M. Lowe</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>vascular cerebral accident</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>gen. arterio sclerosis</b> DUE TO (c) <b>8 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arrhythmia of heart</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>Edith Rodler</b> attended the deceased from <b>Dec. 25, 1961</b> to <b>Jan. 1, 1962</b> that (I) <b>did not</b> saw the deceased alive on <b>Jan. 1, 1962</b> , and that death occurred at <b>1:40 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edith Rodler</b>		22b. DATE <b>1/2/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edith Rodler, M.D.</b>		22d. ADDRESS <b>45 Franklin St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Special 1/5/62</b>		23b. DATE THEREOF <b>1/5/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Balto. National</b>		23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>St. B. Whippert - Foot Entaw Rd.</b>		25a. REC'D BY REGISTRAR <b>JAN 5 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1915

1915

James M. ...

James M. ...

James M. ...

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James M. ...

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
00159 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100157

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Rte 2 Box 27 Telegraph Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Addie</u> Middle <u>HOWMAN</u> Last <u>HOWMAN</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>1</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 April 1919</u> 42 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>National Plastics</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Naelie Whitson</u>		14. MOTHER'S MAIDEN NAME <u>DORA Howell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>MR Charles Clark</u>	
17. INFORMANT <u>MR Charles Clark</u>		Address <u>SAME AS 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>825 X</u> DUE TO <u>Fractured Skull</u> Conditions, if any, which gave rise to immediate cause (b) <u>Sudden</u> (c) <u>due to the underlying cause lost.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rte 175</u>	20f. (City or town) <u>ODENTON</u> (County) <u>AAC MD</u> (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Bustave</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4 Jan. 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Nichols Bethel</u>		22d. LOCATION (City, town, or county) <u>Odenton</u> (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping &amp; Kirkley Funeral Home Md</u>		24a. REC'D BY REGISTRAR <u>Glen Burnie</u> 24b. REGISTRAR'S SIGNATURE <u>William S. Evans</u>	
		DATE <u>JAN 4 '62</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.



1995-1996

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00160

00158

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY in 1b <b>3 years 2 mos. 17 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1101 1/2 Myrtle Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Elizabeth (Malissa) Lyles</b>		<b>4. DATE OF DEATH</b> Month <b>1</b> Day <b>11</b> Year <b>19 62</b>		<b>5. SEX</b> <b>Female</b>			
<b>6. COLOR OR RACE</b> <b>Negro</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>February 23, 1898</b>			
<b>9. AGE</b> (In years last birthday) <b>63</b> yrs.                 IF UNDER 1 YEAR: Months _____ Days _____                 IF UNDER 24 HRS.: Hours _____ Min. _____		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>-----</b>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>William Webster</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>Hattie Lewis</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>			
<b>17. INFORMANT</b> <b>Hospital Records</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> (b) <b>Chronic Brain Syndrome &amp; Cerebral Arteriosclerosis</b> (c) <b>-----</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>-----</b>		INTERVAL BETWEEN ONSET AND DEATH <b>-----</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>-----</b>		<b>20b. DESCRIBE HOW INJURY OCCURED</b> , (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>					
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>10/24</b> , 19 <b>58</b> , to <b>1/11</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>1/11</b> , 19 <b>62</b> , and that death occurred at <b>11 P</b> , from the causes and on the date stated above.		<b>22a. SIGNATURE</b> <b>L. Benedict, M. D.</b>		<b>22b. DATE SIGNED</b> <b>1/12/62</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>L. Benedict, M. D.</b>		<b>22d. ADDRESS</b> <b>Crownsville State Hospital, Maryland</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>1-17-62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Auburn Cem.</b>			
<b>23d. LOCATION</b> (City, town or county) (State) <b>Balt. Md.</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. A. Jackson</b>					
<b>25a. REC'D BY REGISTRAR</b> <b>JAN 17 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thomas</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

# 1

0108

00100

(M)

(1)

Chronic Toxic Syndrome  
Gonorrhea of the Prostate

*Chronic*

and signs of the Chronic Prostate  
Gonorrhea of the Prostate

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.

00161

## CERTIFICATE OF DEATH

00159

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY in lb <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RURAL - Crownsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dead on arrival</u> <u>Anne Arundel General Hospital</u>			d. STREET ADDRESS <u>Herald Harbor</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Francis</u> <u>LYNCH</u>			4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>1962</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 12, 1907</u>		9. AGE (In years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery &amp; Tavern</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Emp.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Unknown Lynch</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-03-0430</u>		17. INFORMANT <u>William Benson-3030 Elliott St. Balto. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Acute pulmonary Embolism</u> 465X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>19</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) <u>the hospital</u> attended the deceased from <u>Jan. 4, 1962</u> to <u>Jan. 25, 1962</u> , that (I) <u>xxx</u> last saw the deceased alive on <u>Jan. 25, 1962</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Richard N. Peeler</u>		M.D. <u>Richard N. Peeler</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>29 Jan. 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Singleton Funeral Home</u>		ADDRESS <u>Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 30 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

STATE OF TEXAS

1910

1910

County of ... State of Texas  
I, the undersigned, Clerk of the County of ... State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the ... as the same appears from the records of the County of ... State of Texas.  
Witness my hand and the seal of said County, at the City of ... State of Texas, this ... day of ... 1910.  
Clerk of the County of ... State of Texas

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21 Film 305  
1-12-62 ams

00162

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00160

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>200 Sixth Ave., S.E., Glen Burnie, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>KEVIN PINKERTON MILLER</b>		4. DATE OF DEATH Month <b>January</b> Day <b>1</b> Year <b>1962</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec 7, 1961</b>		9. AGE (In years last birthday) yrs. <b>24</b>		IF UNDER 1 YEAR Months <b>24</b> Days <b>24</b> Hours <b>24</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Duane Miller</b>			
14. MOTHER'S MAIDEN NAME <b>Alice Pinkerton</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> 983X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>—</b> (c) <b>—</b> DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Baby was submerged in water in diaper bucket</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>1:15 p.m. Jan. 1 1962</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Glen Burnie A.A. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Howard G. Shaub</b>				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>HOWARD G. SHAUB, M. D.</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>1/6/62</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>GIARD Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>McGregor, Iowa</b>			
23. FUNERAL DIRECTOR <b>Hopping + KIRKLEY, Glen Burnie, Md</b>				24a. REC'D BY REGISTRAR <b>JAN 4 '62</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>				DATE <b>1/2/62</b>			

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Dr. ...

Black ...

1/10/52 Grand Central  
Hospitals, New York



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00161

00163

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL or name of nearest town) <b>FT GEORGE G MEADE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
c. LENGTH OF STAY IN 1b <b>UNKNOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FT GEORGE G MEADE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>KIMBROUGH ARMY HOSPITAL</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>NORWOOD</b> Middle <b>-</b> Last <b>MORRIS</b>		4. DATE OF DEATH Month <b>January</b> Day <b>21</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negroid</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>19 Sept 1930</b>
9. AGE (In years last birthday) <b>31</b> yrs.		10. IF UNDER 1 YEAR Months <b>31</b> Days <b>31</b> Hours <b>31</b> Min.	11. IF UNDER 24 HRS. Months <b>31</b> Days <b>31</b> Hours <b>31</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. ARMY</b>	11. BIRTHPLACE (State or foreign country) <b>Florida</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Deceased ?</b>	
14. MOTHER'S MAIDEN NAME <b>Jossie Messer</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes 23 Oct 51 - to present</b>	
16. SOCIAL SECURITY NO. <b>264-46-7966</b>		17. INFORMANT <b>Personnel Records US Army Ft G G Meade, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> 823 X DUE TO Rupture of liver and right kidney Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture, right femur</b> (c) <b>Automobile accident hit tree</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs 28 Min</b> <b>4 hrs 28 Min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture, right femur</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Automobile accident hit tree</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile accident hit tree</b>	
20c. TIME OF INJURY Month, Day, Year <b>5:02A M. Jan 21 1962</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt 175</b>		20f. (City or town) (County) (State) <b>Odenton, Anne Arundel, Md.</b>	
21. I certify that I attended the deceased from <b>21 January 19 62</b> to <b>21 January 19 62</b> , that I last saw the deceased alive on <b>21 January 19 62</b> , and that death occurred at <b>0930A</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>22 Jan 1962</b>	
ACTUAL SIGNATURE <b>Francis C. Dimond Jr.</b> M.D.		DATE SIGNED <b>22 Jan 1962</b>	
PHYSICIAN'S NAME (Type) <b>FRANCIS C. DIMOND JR, MAJOR, MC, Kimbrough Army Hospital Ft G G Meade, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/23/62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Longfellow Funeral Home</b>		22d. LOCATION (City, town, or county) (State) <b>Tallahassee, Florida</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Carl B. Robertson, Funeral Home, Inc.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 26 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 00164 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Film G306 2/2/62 iwk

Reg. Dist. No.

00162

1. PLACE OF DEATH a. COUNTY <u>Shady Side A.A. MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady Side/Annapolis</u>			c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel Gen. Hosp.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
f. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Ann</u> Last <u>Moulden</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>27</u> Year <u>1962</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 12, 1869</u>	9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>America</u>			13. FATHER'S NAME <u>Jacob Gross</u>		
14. MOTHER'S MAIDEN NAME <u>Elizabeth Gross</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Helen Brown 3120 Mendocino Ave</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) <u>  </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Emily H. Wilson</u>			DATE SIGNED <u>11/27/62</u>		
EXAMINER'S NAME (Type) <u>Emily H. Wilson</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/30/1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Bethesda Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Katie R. Williams</u>			24a. REC'D BY REGISTRAR <u>Schweder St.</u>		
ADDRESS <u>322 N.</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

DEATH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100103

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		PLACE OF BIRTH	
MARRIED		OCCUPATION	
EDUCATION		RELIGION	
MANNER OF DEATH		CAUSE OF DEATH	
DISEASE		SYMPTOMS	
TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
SMOKING		ALCOHOL	
DRUGS		OTHER	
SIGNATURE OF EXAMINER		DATE	
TITLE		OFFICE	
ADDRESS		CITY	
STATE		ZIP	

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00165

00163

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Same</b>				b. COUNTY <b>Same</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>				c. LENGTH OF STAY IN 1b <b>14 years</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Box 90 Route 1</b>				d. STREET ADDRESS <b>Same</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Jocie Lou Mullins</b>				4. DATE OF DEATH <b>January 11th. 1962</b>											
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/18/10</b>		9. AGE (In years last birthday) <b>51 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John Horton</b>				14. MOTHER'S MAIDEN NAME <b>Emma Allan</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes give number of service) <b>No</b>				17. INFORMANT <b>Roy Mullins (husband)</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Charred <del>body</del> beyond recognition</b> <b>9/16.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was burned in her own home which caught on fire.</b>											
20c. TIME OF INJURY Month, Day, Year <b>2.35 p.m. 1/12/62 19</b>				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Laurel</b>		(County) <b>A.A.</b>		(State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <b>Gustave H. Faubert</b>				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>				Address (Street, city, town, or county) <b>Glen Burnie, Md.</b>				DATE SIGNED <b>1/12/62</b>							
22b. DATE THEREOF <b>Jan. 13, 1962</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Lisbon Baptist Com. - Lisbon Maryland</b>				22d. LOCATION (City, town, or county) <b>Lisbon</b>				(State) <b>Md.</b>			
23. FUNERAL DIRECTOR <b>DeWitt Donaldson, Laurel, Md.</b>				ADDRESS				24a. REC'D BY REGISTRAR <b>JAN 16 '62</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Francis</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00167

00165

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>1 1/2 hr.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RURAL - Millersville</b> d. STREET ADDRESS <b>Baldwin Hills</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>NOLTE</b>		4. DATE OF DEATH <b>January 14 1962</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 14, 1962</b>		9. AGE (In years last birthday) <b>14</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newborn</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Claude Nolte</b>				14. MOTHER'S MAIDEN NAME <b>Roselee Kathleen Hampton</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Hospital records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>770.0 fetal hydrops (severe)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Rh incompatibility.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) <del>physician</del> attended the deceased from <b>Jan. 14, 1962</b> to <b>Jan. 14, 1962</b> , that (I) <del>last</del> saw the deceased alive on <b>Jan. 14, 1962</b> , and that death occurred at <b>5:30 AM</b> , from the causes and on the date stated above.																			
22a. SIGNATURE <b>S. Borssuck</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) <b>Samuel Borssuck, M.D.</b>				22d. ADDRESS <b>Amos Garrett Blvd., Annapolis, Md.</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1/17/62</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>				23d. LOCATION (City, town or county) (State) <b>Glen Burnie, Md.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley</b>				25a. REC'D BY REGISTRAR <b>JAN 18 '62</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thane</b>											

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00185

STATEMENT OF DEATH

00187

NAME: Anne Arnold  
SEX: Female  
DATE OF BIRTH: Jan. 14, 1902  
PLACE OF BIRTH: Maryland  
EDUCATION: High School  
OCCUPATION: Housewife  
RELIGION: Roman Catholic  
MARRIAGE: Married  
SPOUSE: William Arnold  
DECEASED: Jan. 14, 1982  
PLACE OF DEATH: Anne Arnold General Hospital  
CAUSE OF DEATH: Heart Disease  
HOSPITAL RECORDS: [illegible]

*Handwritten signature*  
[illegible]

NAME: Glen Haver  
SEX: Male  
DATE OF BIRTH: Jan. 14, 1902  
PLACE OF BIRTH: [illegible]  
EDUCATION: [illegible]  
OCCUPATION: [illegible]  
RELIGION: [illegible]  
MARRIAGE: [illegible]  
SPOUSE: [illegible]  
DECEASED: Jan. 14, 1982  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
HOSPITAL RECORDS: [illegible]

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
00168									
01464									
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY in lb 9 years 11 mos. 22 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Myrtle Hammond First Middle Last Pendleton					4. DATE OF DEATH Month Day Year 1 30 19 62				
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 9, 1902		9. AGE (In years last birthday) 59 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Steward					14. MOTHER'S MAIDEN NAME Sarah Hammond				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 289.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Amyloidosis of Kidney and other Organs (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Elephantiasis of Legs								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----				
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- 19 p.m. -----		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/8, 19 52 to 1/30, 19 62, that (I) (we) last saw the deceased alive on 1/30, 19 62, and that death occurred 7:25 P. from the causes and on the date stated above.									
22a. SIGNATURE M.D. L. Benedict, M. D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Crownsville State Hospital, Maryland			22b. DATE 1/31/62 SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 3-62		23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW		23d. LOCATION (City, town or county) (State) Frederick-Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks, III					ADDRESS Annapolis, Md. 43-45 Northwest St.		25a. REC'D BY REGISTRAR DATE FEB 7 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Kraso

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TO HOSPITAL OR AFTER  
death. Page 4  
to FUNERAL DIRECTOR:  
director, page 3 should  
be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

be examined by the hospital or attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00169 CERTIFICATE OF DEATH 00166

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis	
c. LENGTH OF STAY IN lb 4 days		d. STREET ADDRESS Rt-1, Chesterfield Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Elmer PENNINGTON		4. DATE OF DEATH January 12 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 12, 1901	
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintinance		10b. KIND OF BUSINESS OR INDUSTRY State Hospt.	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Delbert F. Pennington		14. MOTHER'S MAIDEN NAME Willie Bird	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Vera J. Pennington		Address #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute coronary occlusion DUE TO (b) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic heart disease		INTERVAL BETWEEN ONSET AND DEATH 12 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from Jan. 8, 1962 to Jan. 12, 1962, that (I) (we) saw the deceased alive on Jan. 12, 1962, and that death occurred at 10:10 PM, from the causes and on the date stated above.		22a. SIGNATURE Richard N. Peeler M.D.	
22c. PHYSICIAN'S NAME (Type) Richard N. Peeler		22b. DATE SIGNED 1/15/62	
22d. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-15-62	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION (City, town or county) (State) Annapolis Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
ADDRESS Annapolis, Md.		DATE JAN 16 '62	



00169

CERTIFICATE OF DEATH

00169

Age 45

Male

White

Married

Single - Annals

Annals General Hospital

Annals General Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be filled out by the attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

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00170

00167

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>AA Co</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA Co</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Linthicum Hgts</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Linthicum Hgts</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1406 Hawthorne Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Julius Frederick Peters</u>		4. DATE OF DEATH Month <u>1</u> Day <u>30</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 5 1885</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>YMCA</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Physical director</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Juergen Frederick Peters</u>		14. MOTHER'S MAIDEN NAME <u>Annie Marie Warnken</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs J. Frederick Peters</u>		Address <u>406 Hawthorne Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443 X Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Cardio-Vascular Disease</u> (c) <u>4 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 1-20 1962</u> to <u>JANUARY 1962</u> , that (I) (we) last saw the deceased alive on <u>1-20 1962</u> , and that death occurred <u>6A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>C.R. MacDonald M.D.</u>		22b. DATE SIGNED <u>1-30-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>C.R. MacDonald</u>		22d. ADDRESS <u>204 Crain Hwy Glen Burnie Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-1-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Swanwick Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Galesville, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>T.A. Hardesty + Son</u>		25a. REC'D BY REGISTRAR <u>Charles E. Kinn</u>	
ADDRESS <u>Galesville, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Kinn</u>	
DATE <u>FEB 5 '62</u>			

00102

00100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before death, if not) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>						c. LENGTH OF STAY IN 1b <b>1 day</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>						d. STREET ADDRESS <b>118 Breitwert Ave.</b>					
3. NAME OF DECEASED (Type or print) <b>Frank Ira PHELPS</b>						4. DATE OF DEATH <b>January 3 1962</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 15, 1884</b>		9. AGE (In years last birthday) <b>77 yrs.</b>		IF UNDER 1 YEAR Months Days Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman (ret.)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hecht Co.</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13. FATHER'S NAME <b>Walter Phelps</b>						14. MOTHER'S MAIDEN NAME <b>Achsa Watts</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>						16. SOCIAL SECURITY NO. <b>578 10 4309</b>		17. INFORMANT <b>Mrs. Ruth Butler</b> Address <b>Odenton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>330X</b> IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> DUE TO (b) <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) <del>did not</del> attended the deceased from <b>1. 2 62</b> to <b>Jan. 3, 1962</b> , that (I) <del>did</del> saw the deceased alive on <b>Jan. 3, 1962</b> , and that death occurred at <b>10:15 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Frank M. Shipley</b>						22b. DATE SIGNED <b>1/4/62</b>		22c. PHYSICIAN'S NAME (Type) <b>FRANK M. SHIPLEY</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						23b. DATE THEREOF <b>7th Jan. '62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		23d. LOCATION (City, town or county) <b>Ft. Meade, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Richard V. Singleton</b>						24a. ADDRESS <b>Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 8 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

(M)

0171

State of Maryland

County of Prince George's

City of Washington

Shirley M. Jones

John A. Jones

John A. Jones

The undersigned, Shirley M. Jones

do hereby certify that

John A. Jones

is the

husband of

Shirley M. Jones

and that they are

the

owners of the

property described in

the

instrument of

transfer to

Shirley M. Jones

and

John A. Jones

are the

owners of the

*Shirley M. Jones*  
*John A. Jones*

Shirley M. Jones

and

John A. Jones

do hereby

certify that

Shirley M. Jones

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Shirley M. Jones

John A. Jones

Shirley M. Jones

John A. Jones

Shirley M. Jones

*Shirley M. Jones*

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
00172 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00169										
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>			c. LENGTH OF STAY IN lb <b>7 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b>			d. STREET ADDRESS <b>Same</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>302 Vill Avenue S.E.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Mrs. Florence Cornelia Phillips</b>					4. DATE OF DEATH <b>January 19th 1962</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/3/80</b>		9. AGE (In years last birthday) <b>82</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Preston</b>					14. MOTHER'S MAIDEN NAME <b>Julia Elliott</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Charles Grierson (Grand son)</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Arteriosclerosis</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>DUE TO</b> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>Gustave H. Faubert</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>1/20/62</b> <b>Glen Burnie, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>1/24/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or country) <b>Ritchie Highway Md</b>			
23. FUNERAL DIRECTOR <b>Frederick D. Miller, Inc 3019 Monument St</b>					24a. REC'D BY REGISTRAR <b>JAN 26 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

M

*Frederick D. Miller*

Frederick D. Miller, Inc 3019 Homestead St  
1/25/62 Cedar Hill Cemetery  
Ritchie Highway Md



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00173

## CERTIFICATE OF DEATH

00170

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>3 months</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Arm</b> d. STREET ADDRESS <b>Box 45</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Moses</b>		First <b>Quickley</b>		Middle <b>Quickley</b>		Last <b>Quickley</b>		4. DATE OF DEATH Month <b>1</b> Day <b>22</b> Year <b>19 62</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 4, 1885</b>		9. AGE (In years last birthday) <b>76</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Grafton Quickley</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Brain Syndrome Associated with Arteriosclerotic Hypertensive Cardiovascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Left Hemiparesis</b>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/22</b> , 19 <b>61</b> to <b>1/22</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>1/22</b> , 19 <b>62</b> , and that death occurred at <b>8</b> AM, from the causes and on the date stated above.									
22a. SIGNATURE <i>Hildegard Heard Reissman</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/22/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D.</b>				22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>					
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-27-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cem</b>		23d. LOCATION (City, town or county) (State) <b>Longgreen, Balto. Co., Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Francis A. Hensley</i>				25a. REC'D BY REGISTRAR <b>DATE JAN 25 '62</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 3 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

00113

00113

State of Ohio  
County of Hamilton  
Cincinnati State Hospital  
Box 15  
October 1, 1933  
Hamilton, Ohio

Hamilton, Ohio  
October 1, 1933  
Hamilton, Ohio

Hamilton, Ohio  
October 1, 1933  
Hamilton, Ohio

Hamilton, Ohio  
October 1, 1933  
Hamilton, Ohio

Hamilton, Ohio  
October 1, 1933  
Hamilton, Ohio

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A/SM  
SM 9/60

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00174 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00171

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b> c. LENGTH OF STAY IN 1b <b>2 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Box 324 Route 8</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b> d. STREET ADDRESS <b>Same</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mrs. Annie Dora Rebstock</b>		4. DATE OF DEATH Month Day Year <b>January 26th, 19 62</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/17/82</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Georges Herzerberger</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Schnitter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Benjamin Rebstock (husband)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General <del>Arteriosclerosis</del> Arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTORY <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gustave H. Faubert</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>1/28/62</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-29-62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or country) (State) <b>G. G. Co Md.</b>	
23. FUNERAL DIRECTOR <b>McCauley</b>		24a. REC'D BY REGISTRAR <b>130 E Ford Ave.</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE <b>JAN 30 '62</b>	

151

0134



*Handwritten signature*

*Handwritten text, possibly a date or reference number.*

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00175 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00172

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Same</b>		b. COUNTY <b>Same</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 27</b>		c. LENGTH OF STAY IN 1b <b>2 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8136 Fort Smallwood Road</b>				d. STREET ADDRESS <b>Same</b>	
3. NAME OF DECEASED (Type or print) <b>Kenton R. Rentzell</b>		4. DATE OF DEATH <b>January 12th, 19 62</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>12/9/11</b>		9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Marina</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Robert Kentzell</b>		14. MOTHER'S MAIDEN NAME <b>Martha Rutledge</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NO 212-10 -7273</b>		17. INFORMANT <b>Mrs. K.R. Rentzell (wife)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Self inflicted wound to the brain with a 30 caliber</b> DUE TO (b) <b>rifle Remington.</b> DUE TO (c) <b>Sudden</b>				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): <b>As explained in #18.</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) <b>As explained in #18.</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>1:30 A.M.</b> p.m. <b>1/12/62</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Baltimore 27</b>		20g. (County) <b>A.A.</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Gustave H. Faubert</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 1/12/62 DATE SIGNED	
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Glen Burnie, Md.</b>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-15-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>West Liberty Cemetery</b>	
22d. LOCATION (City, town, or country) <b>Parkton, Md.</b>		22e. REC'D BY REGISTRAR <b>JAN 16 '62</b>		22f. REGISTRAR'S SIGNATURE <b>Arthur S. Thane</b>	

Brooks Funeral Service York Rd. Towson Md.





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00176

00173

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Annapolis</u>		d. STREET ADDRESS <u>Rt-1, Box-28</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Vivian</u> Middle <u>G</u> Last <u>ROBINSON</u>				<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>12</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 10, 1881</u>	
9. AGE (In years last birthday) <u>80 yrs.</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>ALBERT A TYLER</u>			
14. MOTHER'S MAIDEN NAME <u>CATHERINE WEBSTER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>ROBERT W. ROBINSON</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary edema</u> DUE TO (b) <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diabetic m.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hr</u> <u>48 hr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetic m.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>1</u> e.m. <u>11</u> p.m. <u>02</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Jan. 12, 1962</u> to <u>Jan. 12, 1962</u> , that (I) (the hospital) last saw the deceased alive on <u>Jan. 12, 1962</u> , and that death occurred at <u>7:30 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank M. Shipley</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/12/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frank M. Shipley, M.D.</u>				22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 15-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cent</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Tyler Sons</u>				ADDRESS <u>Annapolis Md</u>		25a. REC'D BY REGISTRAR <u>JAN 16 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

00150

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00177					00174						
Item 8 Film G305 1/22/62 iwr											
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY Anne Arundel MARYLAND					a. STATE Maryland b. COUNTY Charles						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Namjemov 08x.2						
c. LENGTH OF STAY IN 1b 1 yr. 1 mo.					d. STREET ADDRESS Rt. 1 Box 112						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last Rosie Montgomery Rollins					4. DATE OF DEATH Month 1 Day 5 Year 19 62						
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1926 January 28, 1927/35 yrs.		9. AGE (In years last birthday) 35			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William T. Montgomery					14. MOTHER'S MAIDEN NAME Laura ?						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 213-22-0916		17. INFORMANT Hospital Records			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Hypostatic pneumonia due to cerebral thrombosis of brain											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Cerebral and Generalized Arteriosclerosis											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic Reaction, Paranoid Type										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 12/7 1960 1/5										20d. INJURY OCCURRED While Not While at work at work <input type="checkbox"/> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/7 1960 to 1/5 1962, that (I) (we) last saw the deceased alive on 1/5 1962, and that death occurred at 3:20 a.m. from the causes and on the date stated above.											
22a. SIGNATURE L. BENEDICT M.D.										22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. BENEDICT M.D.										22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 1/9/62										23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Arlington National										23d. LOCATION (City, town or county) (State) Arlington Va.	
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hoffman Funeral Home 909-6 St NW										25a. REC'D BY REGISTRAR DATE 1-5-62	
										25b. REGISTRAR'S SIGNATURE Arthur L. Kneap	

M

212  
L. B. ...  
... ..

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00178

00175

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b> c. LENGTH OF STAY IN b <b>5 MONTHS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riva</b> d. STREET ADDRESS <b>% Manor House</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Albert H. Seligman Sr.</b>		4. DATE OF DEATH Month <b>January</b> Day <b>13</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 29, 1899</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - PIPE FITTER - PLUMBING</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 1925-</b>		16. SOCIAL SECURITY NO. <b>214 013502</b>	
17. INFORMANT <b>ALBERT SELIGMAN, JR.</b>		Address <b>CHALK POINT RD. WEST RIVER, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arterio sclerosis cardio vascular disease</b> DUE TO (b) <b>Arterio sclerosis cardio vascular disease</b> DUE TO (c) <b>Arterio sclerosis cardio vascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422.2</b>		INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/30</b> , 19 <b>61</b> , to <b>1/13</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>1/13</b> , 19 <b>62</b> , and that death occurred at <b>11:30</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>G. Church</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Gerard Church</b>		22d. ADDRESS <b>121 Cathedral St. Annapolis, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-16-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN CEM.</b>		23d. LOCATION (City, town or county) (State) <b>STAT BLENIE - A.A. Co. MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Cowan &amp; Son Inc</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 17 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>DATE</b>		25c. REGISTRAR'S SIGNATURE <b>DATE</b>	

00132

CERTIFICATE OF DEATH

00132

Blank certificate form with faint lines and text, including fields for name, date, and location. The text is mirrored and mostly illegible.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00179 CERTIFICATE OF DEATH 00176											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>						d. STREET ADDRESS <u>Rt. 2, Box 514B</u>					
3. NAME OF DECEASED (Type or print) First <u>Patricia</u> Middle <u>M.</u> Last <u>Shumaker</u>						4. DATE OF DEATH Month <u>January</u> Day <u>20</u> Year <u>19 62</u>					
5. SEX <u>Female</u>						6. COLOR OR RACE <u>White</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>8/28/34</u>					
9. AGE (In years last birthday) <u>27</u> yrs.						10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>					
13. FATHER'S NAME <u>Eugene Andrews Daly</u>						14. MOTHER'S M maiden NAME <u>Mary Elizabeth Bresnahan</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>577-42-3591</u>					
17. INFORMANT <u>Hospital records</u>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLUS</u> DUE TO <u>PHLEBOTROMBOSIS LEFT ILLIAC VEIN</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>UNKNOWN</u> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (the school) attended the deceased from <u>Jan. 20, 1962</u> to <u>Jan. 20, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan. 20, 1962</u> , and that death occurred at <u>3:00 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Edward S. Beck</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>1/22/62</u>											
22c. PHYSICIAN'S NAME (Type) <u>Dr. Edward S. Beck</u> 22d. ADDRESS <u>71 Franklin St., Annapolis, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
23b. DATE THEREOF <u>1/28/62</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens Cem.</u>											
23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>											
24 FUNERAL DIRECTOR'S SIGNATURE <u>Mac H. Morris</u> ADDRESS <u>3901 N. Fairfax Dr. Arlington, Va.</u>											
25a. REC'D BY REGISTRAR <u>JAN 26 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>											

00132

CERTIFICATE OF DEATH

00132



James Franklin General Hospital

Admission

Admission

Box 2118

James Franklin General Hospital

January 20

Shawnee

Shawnee

27

8/28/31

White

Female

U.S.A.

Washington, D.C.

Residence

Early Discharge

Discharge

Hospital records

1914-1915

110

Pharmaceuticals  
Bureau of Pharmacy

Chemical  
Bureau

General

Dr. Edward S. Pack

21 Franklin St., Cambridge, Mass.

3:00 PM

Jan. 20

Vol. 20

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>AA</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glennburnie</u> c. LENGTH OF STAY IN 1b <u>15 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>30 N. J. NW.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>St. Mary's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Mary's</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Richard Smith</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>13</u> Year <u>1962</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov-7 '71</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumberman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Saw mill</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>Columnbas Smith</u>		14. MOTHER'S MAIDEN NAME <u>  </u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>320-05-1754</u>	
17. INFORMANT <u>John B. Smith</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of mouth</u> 144 X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6-8 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 13, 1962</u> , to <u>Jan 13, 1962</u> ; that (I) (we) last saw the deceased alive on <u>Jan 13, 1962</u> , and that death occurred at <u>11:30 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Chas. L. Ball, Jr.</u>		22b. DATE SIGNED <u>1/3/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES H. BALL JR.</u>		22d. ADDRESS <u>Linthicum, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-16-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GREEN LAWN CEM.</u>		23d. LOCATION (City, town or county) (State) <u>Cambridge, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping &amp; KIRKLEY</u>		25a. REC'D BY REGISTRAR <u>  </u>	
ADDRESS <u>Green Burnie, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>JAN 16 '62</u>			

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**CERTIFICATE OF DEATH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00181

00178

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PASADENA</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 488A Rte #5</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>SMITH</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>1</b> Day <b>12</b> Year <b>1962</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-5-1900</b>	9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>12</b> Hours <b>19</b> Min.	IF UNDER 24 HRS. Months <b>6</b> Days <b>12</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CHEMICAL MANUF.</b>		11. BIRTHPLACE (State or foreign country) <b>M. A. C. O. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>CHARLES SMITH</b>				14. MOTHER'S MAIDEN NAME <b>BEATRICE WILLIAMS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-01-9047</b>		17. INFORMANT Address <b>GRACE G. SMITH - PASADENA - MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malnutrition + dehydration</b> <b>151X</b> DUE TO <b>Carcinoma of the stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>25 days</b> <b>undetermined</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1-11, 1962</b> , that (I) (we) last saw the deceased alive on <b>5-10, 1962</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Barber C. Palmer Jr.</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>BARBER C. PALMER JR.</b>	
22d. ADDRESS <b>77 FRANKLIN ST. ANNAPOLIS, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/16/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Zion Church</b>		23d. LOCATION (City, town, or county) (State) <b>MAGOTHING - MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Marshall P. Hayes, 638 N. Calmar St.</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 15 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

*Belts. 17, Md.*

Ennis 1/10/24 M. J. on Church Meeting - M.D.

212-01-004 George C. Smith - Pasadena - M.D.

Charles Williams

Charles Williams M.D. (C. M.D.)

M.D.

Male (absent)

x

William

Boy 488 A Rte #2

Pasadena

Life

Pasadena

M.D.

Boy 488 A Rte #2

Smith

10-2-1900 61

15

62

Ann H. Foster

Ann H. Foster



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 17, MARYLAND

00182

Item 9 Film C505 1/25/62 iwk

CERTIFICATE OF DEATH

00179

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>South Carolina</b> b. COUNTY <b>Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Columbia</b>	
c. LENGTH OF STAY IN 1b <b>1 y, 1 m, 14 d.</b>		d. STREET ADDRESS <b>R.F.D. #1, Box 183</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SPRY</b> Middle <b>Bosie</b> Last <b>Spray / alias John Doe/</b>		4. DATE OF DEATH Month <b>1</b> Day <b>2</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1909</b>
9. AGE (In years lost birthday) yrs. <b>52 1/2</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>2</b> Hours <b>1</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Edna Spry</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental Deficiency with Cerebral Atrophy</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/18</b> 19 <b>60</b> to <b>1/2</b> 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>1/2</b> 19 <b>62</b> , and that death occurred at <b>8:10 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L. BENEDICT M.D.</b>		22b. DATE SIGNED <b>1/2 19 62</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. BENEDICT M.D.</b>		22d. ADDRESS <b>CROWNVILLE STATE HOSPITAL</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>1-11-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Ignace</b>		23d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Beese, Jr. - Funer. Md.</b>		25a. REC'D BY REGISTRAR DATE <b>1 2 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>William S. Thaw</b>			

00130

CERTIFICATE OF DEATH

00130



Signature  
J. D. [illegible]

Witness the State of [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 shall be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00183

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00180

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A.H.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>100 ANNAPOLIS ST.</u>		d. STREET ADDRESS <u>100 ANNAPOLIS ST.</u>	
3. NAME OF DECEASED (Type or print) <u>HENRIETTA</u> First <u>LIHHIAN</u> Middle <u>STALLINGS</u> Last		4. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-2-1871</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William SAUMENIG</u>		14. MOTHER'S MAIDEN NAME <u>HENRIETTA BASIL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT Address <u>Mrs. Boyd J. Foust #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4-20-0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Arteriosclerotic Heart Disease</u> DUE TO <u>(c)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 hr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 10, 1958</u> to <u>June 29, 1962</u> that (I) (we) last saw the deceased alive on <u>1-29-1962</u> and that death occurred at <u>8:55 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James R. Martin</u>		22b. DATE SIGNED <u>1-30-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>		22d. ADDRESS <u>6 SHAW ST. ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-31-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		23d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u>		25a. REC'D BY REGISTRAR <u>FEB 1 '62</u>	
ADDRESS <u>ANNAPOLIS, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>C. J. H. H. H.</u>	

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10183

CERTIFICATE OF DEATH

UNITED STATES

(M)

THIS CERTIFICATE OF DEATH is to be filled out by the physician or other person who has attended the deceased, or by the coroner or other person who has examined the body, or by the registrar or other person who has received the body for burial or cremation.

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Place of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Signature of physician or other person who has attended the deceased: \_\_\_\_\_

10. Signature of coroner or other person who has examined the body: \_\_\_\_\_

11. Signature of registrar or other person who has received the body for burial or cremation: \_\_\_\_\_

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00184

## CERTIFICATE OF DEATH

00181

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
c. LENGTH OF STAY IN b.				d. STREET ADDRESS <u>1403 West. St.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Joseph</u> Middle <u>T.</u> Last <u>TALLEY</u>				<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>5</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 23, 1883</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEERMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>WILLIAM TALLEY</u>				14. MOTHER'S MAIDEN NAME <u>MARY TRAVIS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or date of service) <u>  </u>				16. SOCIAL SECURITY NO. <u>  </u>			
17. INFORMANT <u>Annie C. Talley</u>				Address <u>  </u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>288X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RENAL FAILURE</u> DUE TO (c) <u>GOUT</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u> <u>7 DAYS</u> <u>8 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		Month, Day, Year <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that (I) <u>  </u> attended the deceased from <u>Dec. 31, 1961</u> to <u>Jan. 5, 1962</u> , that (I) <u>  </u> last saw the deceased alive on <u>Jan. 5, 1962</u> , and that death occurred at <u>1:15 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward S. Beck</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Edward S. Beck, M.D.</u>				22d. ADDRESS <u>71 Franklin St., Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-8-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		23d. LOCATION (City, town or county) <u>Annapolis Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Julien M. Saylor Sr</u>				ADDRESS <u>Annapolis Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 9 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

00182

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*Handwritten signature*

72 Franklin St., Cambridge, Mass.

W. A. ...



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
5M 9/60

<div> <div> <div>Item 18&amp;Film 308 3-9-62</div> <div>18&amp;Film 308 3-9-62</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div> <div>00185</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>00182</div> </div> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel County</b> <b>MARYLAND</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>401 Paradise Road - Riva, Md.</b> d. STREET ADDRESS				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>CHARLES TERRY</b>					<b>4. DATE OF DEATH</b> Month Day Year <b>Jan 5, 1962 19</b>				
<b>5. SEX</b> <b>male</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>8-27-61</b>		<b>9. AGE</b> (In years last birthday) yrs. <b>4</b> <b>8</b> <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland - Baltimore City</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>ROBERT L. TERRY</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>JANET COLLINS</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)					<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Address</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute laryngeal tracheitis and interstitial pneumonitis</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>					<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <b>EXAMINER'S NAME</b> (Type) <b>RT Fisher</b>					<b>CHIEF MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>January 5, 1962</b>				
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>			<b>22b. DATE THEREOF</b> <b>1-10-62</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>MT OLIVET CEMETERY</b>		<b>22d. LOCATION</b> (City, town, or country) (State) <b>WASHINGTON, D. C.</b>		
<b>23. FUNERAL DIRECTOR</b> ADDRESS <b>Francis J. Collins 3821-14th St. N.W. Wash. D.C.</b>					<b>24a. REC'D BY REGISTRAR</b> <b>JAN 11 '62</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur A. Thomas</b>		

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James E. Collins

James E. Collins

102 Seventh Street - N.W.

James E. Collins

James E. Collins

James E. Collins

8-27-31

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U.S.A.

Maryland

James

JAMES COLLINS

ROBERT E. TERRY

*James E. Collins*

James E. Collins

D. C.

WASHINGTON

MT OLIVET CEMETERY

1-10-32

FINAL



TO HOSPITAL OR MORGUE: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>A.A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-A.A. Co.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>X Pasadena</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Outling-Road.</u>		d. STREET ADDRESS <u>Outling Road</u>	
3. NAME OF DECEASED (Type or print) <u>Edna E. Thomas</u>		4. DATE OF DEATH <u>JAN. 4 1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 17-1882</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (County & State, or foreign country) <u>Taneytown-Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Wm. F. Kehn</u>		14. MOTHER'S MAIDEN NAME <u>ANNA B. Crouse</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>HARRIET-LOOMAN-ROUTE 3-Pasadena</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA, TERMINAL</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED CARCINOMATOSIS</u> DUE TO (c) <u>CARCINOMA, LEFT BREAST</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 HOURS</u> <u>6 MONTHS</u> <u>1 YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>11-27</u> , 19 <u>61</u> , to <u>11-27</u> , 19 <u>61</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>11-27</u> , 19 <u>61</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur Lankford Jr.</u> M.D.		22b. DATE SIGNED <u>12-1-4-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR.</u>		22d. ADDRESS <u>2934 MOUNTAIN RD. PASADENA, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/8/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Grace Reformed Ch. Taneytown, Md</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. B. Whippert - 1 Fox Entow Rd</u>		25a. REC'D BY REGISTRAR <u>JAN 8 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>			

0810

108104

DATE: 20.11.2019

## CERTIFICATE OF DEATH

Reg. Dist. No.

00184

00187

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft George G Meade</b> c. LENGTH OF STAY IN 1b <b>Unk</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kimbrough Army Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mississippi</b> b. COUNTY <b>Alcorn</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cornith</b> d. STREET ADDRESS <b>210 South Parkway</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Oneal</b> Last <b>Thomas</b>		4. DATE OF DEATH Month <b>January</b> Day <b>1</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 Nov 1928</b>
9. AGE (In years last birthday) <b>33</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>	11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Deceased</b>	
14. MOTHER'S MAIDEN NAME <b>Deceased</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>Oct 1949 to date 406-26-8884</b>		17. INFORMANT <b>Personnel Records US Army Ft George G Meade, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Basilar skull fracture with subarachnoid hemorrhage</b> 823 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto accident hit pole</b>	
20c. TIME OF INJURY Month, Day, Year <b>0600A Jan 1 19 62</b>	20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not while at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt 175 Odenton, Md</b>	20f. (City or town) (County) (State) <b>Odenton, Anne Arundel, Md</b>
21. I certify that I attended the deceased from <b>1 Jan</b> , 19 <b>62</b> , to <b>1 Jan</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>1 Jan</b> , 19 <b>62</b> , and that death occurred at <b>0612A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Sherman S. Robinson</b> M.D.		ADDRESS (Street, city or town, state) <b>Kimbrough Army Hospital Ft Geo G Meade, Md</b>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>SHERMAN S. ROBINSON, CAPTAIN, MC</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>1/3/62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Coleman Funeral Home</b>	22d. LOCATION (City, town, or county) (State) <b>Corinth, Mississippi</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gail B. Wetherell</b>		24a. REC'D BY REGISTRAR <b>JAN 5 '62</b>	
ADDRESS <b>6306-Belair Road, Baltimore-6, Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ST. JOHNS—KIAH TO THEMTRAD STAIRS—GALVANA

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TO HOSPITAL OR FUNERAL HOME. The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. Page 5 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00188

00185

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Homér</b> Middle <b>F.</b> Last <b>TRIPP</b>		4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9, 1876</b>
9. AGE (In years last birthday) <b>86 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Draftsman</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James O. TRIPP</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. William H. Tripp</b>		Address <b>5903 33rd ave Hyattsville, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> 570.5 DUE TO <b>Heart failure</b> Conditions, if any, which gave rise to immediate cause (b) <b>Mechanical small bowel obstruction</b> (c) <b>10 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from <b>1-13</b> , 19 <b>62</b> to <b>Jan. 19, 1962</b> , that (I) (the doctor) last saw the deceased alive on <b>Jan. 19, 1962</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Barber C. Palmer J.</b>		22b. DATE <b>7:45 PM 1/20/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Barber C. Palmer</b>		22d. ADDRESS <b>77 Franklin St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 23, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co. Pikesville, Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 23 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles D. Fournier</b>			

00183

STATEMENT OF DEATH

00183

Place of birth

Married

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

Place of birth

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TO HOSPITAL OR AFTER  
TO FUNERAL DIRECTOR:  
The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the attending physician and completely filled in. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00189 CERTIFICATE OF DEATH 00186

1. PLACE OF DEATH a. COUNTY <u>AA</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HARWOOD</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Harwood</u>			
c. LENGTH OF STAY IN 1b <u>21 MONTHS</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elsie</u> <u>MAE</u> <u>TUCKER</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>3</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 30, 1898</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State or foreign country) <u>CHANEY Station, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>BENJAMIN Hardesty</u>				14. MOTHER'S MAIDEN NAME <u>SARAH E. CHANEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>				16. SOCIAL SECURITY NO. <u>218-36-3995</u>		17. INFORMANT <u>MRS MIRIAM Hardesty Lothian Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420</u> <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis C.V. Disease</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): <u>Three previous Coronaries</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>61</u> , to <u>Jan</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>16 Dec</u> , 19 <u>61</u> , and that death occurred at <u>1:58</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>RR Harson</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>  </u>	
22c. PHYSICIAN'S NAME (Type) <u>  </u>				22d. ADDRESS <u>  </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/7/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT ZION</u>		23d. LOCATION (City, town or county) (State) <u>Lothian Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardesty</u>				ADDRESS <u>Salisbury Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 16 '62</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>	

2310

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00190						00187					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			Ann Arundel.			a. STATE			b. COUNTY		
			MARYLAND			Maryland			Baltimore ✓		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY in 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
Crownsville			3 weeks			Baltimore.			3001-4		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Crownsville State Hospital						830 Carroll St.					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH			5. AGE (In years last birthday)		
First Middle Last						Month Day Year			IF UNDER 1 YEAR		
Dora W. WATSON						January 6 1962			Months Days Hours Min.		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		colored		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		1902-Nov. 22		59 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Housewife						Ballo. Md			U. S. A.		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Walter Willis						Bertha <del>Wattson</del> Bacon					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address					
						Hospital records.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coma											
592X DUE TO											
Conditions, if any, which gave rise to immediate cause (b) Uremia											
(e), stating the underlying cause last. } DUE TO Chronic nephritis.											
i CBS' anastomosis & arteriosclerosis.										24 h.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from 12:29, 1961, to 1:06, 1962 that (I) (we) last saw the deceased alive on 1:06, 1962, and that death occurred at 1:06 AM, from the causes and on the date stated above.											
22a. SIGNATURE						ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
James D. Blount M.D.										1/7/62	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
James D. Blount						Crownsville State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
Burial		1/10/62		St. Peter's Cem.		Ballo. Md.					
24. FUNERAL DIRECTOR'S SIGNATURE						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Katie R. Willard						322 - School St.		DATE 1-JAN 9 '62		Arthur S. Hanna	





**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

00191

Item 8 Film G306 2/5/62 iwk

app. by medical  
44-11188

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>601 Pamela Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nora</b> Middle <b>Webb</b> Last <b>Webb</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>30</b> Year <b>19 62</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1878</b> <b>Feb. 9, 1888</b>
9. AGE (In years lost birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min.	IF UNDER 24 HRS. Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>August Schwartz</b>		14. MOTHER'S MAIDEN NAME <b>Augusta Wocksmuth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>161X</b>	
17. INFORMANT <b>Mrs. L. Thorn, same as 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Larynx</b> DUE TO (b) <b>161X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 10, 1961</b> to <b>Jan. 30, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan. 3, 1962</b> , and that death occurred at <b>6:11</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Samuel Rubin</b>		22b. ADDRESS <b>201 Patapsco Ave, Balto. 25</b>	
22c. PHYSICIAN'S NAME (Type) <b>Samuel Rubin, M.D.</b>		22d. ADDRESS <b>201 Patapsco Ave, Balto. 25</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/1/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>		23d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley, Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 1 1962</b>	
25b. REGISTRAR'S SIGNATURE		25c. DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00101

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John Davis

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00192

00189

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riviera Beach</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>258 Meadow Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mae</u> Middle <u>Anna</u> Last <u>Weedon</u>		4. DATE OF DEATH Month <u>January</u> Day <u>28</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 10, 1887</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Curran</u>		14. MOTHER'S MAIDEN NAME <u>Stramsky</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mrs. Erma Chambers</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Coronary Sclerosis</u> DUE TO <u>  </u> (c) <u>Arteriosclerotic Cardio Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>5 years</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 15, 1962</u> to <u>Jan. 28, 1962</u> , that (I) ( <u>was</u> ) last saw the deceased alive on <u>Jan. 15, 1962</u> , and that death occurred at <u>6:05 P.</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Brady Smith</u>		22b. DATE SIGNED <u>Jan. 30, 62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Brady Smith M.D.</u>		22d. ADDRESS <u>8471 Fort Smallwood Road</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 31, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gonce</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 1 '62</u>	
ADDRESS <u>4001 Ritchie Hwy. (25)</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

George J. Gonce



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be completed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00193

## CERTIFICATE OF DEATH

00190

Item 1 Film G305 1/17/62 iwk

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Eastport</b> c. LENGTH OF STAY IN 1b <b>3 mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Private home-1223 McKinley St.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Md</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Tracy's Landing</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ira Victoria Wilkerson</b>		4. DATE OF DEATH Month <b>1</b> Day <b>9</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1876</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>5</b>	11. IF UNDER 24 HRS. Hours <b>8</b> Min. <b>5</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Richard Sherbert</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Wayson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Mr. Eldridge Wilkerson, Tracy's Landing</b>		Address <b>Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial failure</b> 4 82X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic bronchiectasis</b> DUE TO (c) <b>intestinal grippe with acidosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-6-1962</b> to <b>1-9-1962</b> , that (I) (we) last saw the deceased alive on <b>1-9-1962</b> , and that death occurred at <b>1:15 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Emily H. Wilson</b>		22b. DATE SIGNED <b>1-9-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Emily H. Wilson</b>		22d. ADDRESS <b>Harwood, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 12, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Friendship Church Cem</b>	23d. LOCATION (City, town or county) (State) <b>Friendship, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hutchins Funeral Home</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 12 '62</b>	
ADDRESS <b>Bowings Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

1913

CERTIFICATE OF DEATH

1913

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Lincoln, Nebraska

8 m.

Lincoln

John Michael Smith

John Michael Smith

Mr. Michael Smith, 1234 N. Lincoln

Harwood, Nebraska

Harwood, Nebraska

Lincoln, Nebraska

Lincoln, Nebraska

Lincoln, Nebraska



TO HOSPITAL OR FUNERAL HOME. The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

VR A15 (4)  
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00194  
CERTIFICATE OF DEATH  
00191

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>924 Bayridge Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Mabel</b> Middle <b>E.</b> Last <b>WOOD</b>		4. DATE OF DEATH Month <b>January</b> Day <b>12</b> Year <b>1962</b>	
5. SEX <b>F male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 4, 1876</b>
9. AGE (In years last birthday) <b>85 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Job Griscom</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Stewart</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>John G. Wood Jr.</b>	
17. INFORMANT <b>John G. Wood Jr.</b>		Address <b>(2)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> 4200 DUE TO (b) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Senility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>James R. Martin</b> attended the deceased from <b>Jan. 12, 1962</b> to <b>Jan. 12, 1962</b> , that (I) <b>James R. Martin</b> saw the deceased alive on <b>Jan. 12, 1962</b> , and that death occurred at <b>2:00 PM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>James R. Martin</b> M.D.	
22b. DATE SIGNED <b>1-13-62</b>		22c. PHYSICIAN'S NAME (Type) <b>James R. Martin</b>	
22d. ADDRESS <b>6 Shaw St., Annapolis, Md.</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-15-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff</b>		23d. LOCATION (City, town or county) (State) <b>Annapolis Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>Jan 16 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>		25c. ADDRESS <b>Annapolis, Md.</b>	

100131

CERTIFICATE OF DEATH

100131



NAME: [illegible] SEX: [illegible] AGE: [illegible]  
DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]

DATE: [illegible] TIME: [illegible]  
SIGNATURE: [illegible] TITLE: [illegible]

[illegible text]

[illegible text]

[illegible text]



TABLE 1. Summary of the 1000 most abundant proteins in the plasma of patients with rheumatoid arthritis

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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63

00196

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00193

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>Box-249</b>	
3. NAME OF DECEASED (Type or print) <b>Marie ZEMAN</b>		4. DATE OF DEATH Month <b>January</b> Day <b>8</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 17, 1887</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Chlad</b>		14. MOTHER'S MAIDEN NAME <b>Mary (Unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Mr. Stephen Zeman</b>		Address <b>Same As #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardio-</b> (c) <b>vascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) <b>in person</b> attended the deceased from <b>Jan. 1, 1962</b> to <b>Jan. 7, 1962</b> , that (I) <b>xx</b> saw the deceased alive on <b>Jan. 7, 1962</b> , and that death occurred at <b>3:00 AM</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>Sylvia M. Lim, M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>1/8/62</b> 22c. PHYSICIAN'S NAME (Type) <b>Sylvia Lim, M.D.</b> 22d. ADDRESS <b>Mayo Road, Edgewater, Md.</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>11th Jan. 1962</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Pk.</b> 23d. LOCATION (City, town or county) (State) <b>Glen Burnie, Maryland</b> 24. FUNERAL DIRECTOR'S SIGNATURE <b>R. V. Singleton</b> ADDRESS <b>Glen Burnie, Md.</b> 25a. REC'D BY REGISTRAR <b>JAN 9 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

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TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

00197

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 11-12 etc. Film Q305 1/16/62

00194

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>7 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Plaza Manor Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Adolph</b> Middle <b>Zonglovich</b> Last <b></b>		4. DATE OF DEATH Month <b>January</b> Day <b>6</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>? 1883</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Not known</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Not known</b>	
11. BIRTHPLACE (State or foreign country) <b>unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>Not known</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>213-18-3299</b>	
17. INFORMANT <b>Miss MaLean Balto. D.P.W.</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 4-22-61 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. DUE TO (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs. plus</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Jacksonian epilepsy secondary to skull fracture and subdural hematoma</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>February 6, 1960</b> to <b>January 5, 1962</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>December 22, 1961</b> and that death occurred at <b>8A M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>James M. Pair</b>		22b. DATE SIGNED <b>January 6, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>James M. Pair, M.D.</b>		22d. ADDRESS <b>400 N. Carrollton Ave. Balto. 23, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-10-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 10 '62</b>	
ADDRESS <b>802 Madison Ave., Balto., Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

(M)

ESTIMATE OF DEATH

January 6, 1902

January 6, 1902

January 6, 1902

January 6, 1902

January 6, 1902

January 6, 1902

January 6, 1902

January 6, 1902

January 6, 1902

January 6, 1902